FACTORS AFFECTING PERFORMANCE OF PROFESSIONAL NURSES IN NAMIBIA

by

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DECLARATION

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I declare that ***FACTORS AFFECTING PERFORMANCE OF PROFESSIONAL NURSES IN NAMIBIA*** *is* my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE DATE

(Mrs M H Awases**)**

This Study is dedicated to my sons, Michael and Angelo

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First and foremost, to my heavenly Father who gave me the strength through difficult and trying times, I give Him the glory and honour.

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Human resources are the most important assets of any health system. In recent years it has been increasingly recognised that improving the performance of health personnel should be at the core of any sustainable solution to health system performance. However, it is widely acknowledged that health systems are not producing the desired output of health interventions due to factors such as insufficient skilled and experienced health personnel, demotivated health personnel, lack of management skills, poor working conditions and environment, and inadequate remuneration.

This study explores the factors that affect performance of nurses in Namibia with the aim of providing a management framework for improving the performance of professional nurses.

The study followed a quantitative research approach using an explorative descriptive design. A survey method using questionnaires was applied. The reaction to the study was positive as a response rate of 75.8% was obtained. Data analysis included identifying and comparing existence or absence of factors using the SSPS package. The target population included all professional nurses in Oshana, Otjozondjupa and Khomas regions.

Baseline results revealed various factors which affect performance. The study revealed that hospitals currently have deficiencies in human resource management aspects such as recognition of employees who perform well, working conditions, implementation of performance appraisal systems,

feedback on performance outcomes and management skills. These aspects are strongly associated with level of performance of health personnel.

Based on the results, a management framework was proposed. The framework consists of activities for enhancing the nursing profession; strengthening knowledge and expertise, including management skills; improving performance; and generating knowledge through research.

Keywords: Performance, human resources management, professional nurses, skills and competencies, performance measurement, appraisal systems, leadership, motivation, organizational factors.

Table of contents **Page**

CHAPTER 2: LITERATURE REVIEW

CHAPTER 3: RESEARCH METHODOLOGY

CHAPTER 4: DATA ANALYSIS

TABLE **PAGE**

FIGURE **PAGE**

LIST OF APPENDICES

CHAPTER 1: INTRODUCTION AND ORIENTATION TO THE STUDY

1. 1 INTRODUCTION

Improving the productivity and performance of health workers to ensure that health interventions are efficiently delivered continues to be a major challenge for African countries. Human resources for health, consisting of clinical and non-clinical staff, are the most important assets of health systems. The performance of a health organization depends on the knowledge, skills and motivation of individuals. It is therefore important for employers to provide suitable working conditions to ensure that the performances of employees meet the desired standards.

It is widely acknowledged that health workers are not producing the desired output of health interventions. Many have echoed this concern, for example, ministers of health during the fifty-second session of the WHO Regional Committee for Africa (WHO 2002a:2) and other organizations and policy- and decision-makers at the high-level forum on the millennium development goals (High-LevelForum 2004:1, World Bank 2000:5). It was stated that insufficient health personnel, in terms of numbers and level of performance, is one major constraint in achieving the millennium development goals (MDGs) for reducing poverty and diseases. Some of the actions proposed to rectify this situation include improving the motivation, retention, productivity and performance of health workers, and mobilizing trained staff who are

unemployed or working in other sectors to return to the health sector (High-Level Forum 2004:7, Stilwell 2001:2).

This study is designed to identify and analyze factors that negatively and positively affect performance of professional nurses in Namibia and to explore factors that are strongly associated with improved performance in order to suggest strategies for monitoring and improving their performance.

1. 2 BACKGROUND

African countries are trying to improve the functioning of health care delivery systems to ensure that the populations they serve receive timely quality care. Health care is labour-intensive, making human resources one of the most important inputs in health care delivery (WHO 2000:3).

Health care in Africa faces difficult challenges such as shortage of health workers, increased case loads for health workers due to migration of skilled health personnel, and the double burden of disease and the HIV/AIDS scourge that affect both the general population and health personnel. A prerequisite for a well-functioning health system is a well-motivated staff that carries out their work according to standards set by the organization (Dielem, Coung, Anh & Martineau 2003:1; Awases, Gbary, Nyoni, & Chatora 2004:53-57). This implies that human input in terms of work by well-motivated and productive human beings will yield the required results.

The Ministry of Health and Social Services (MOHSS) in Namibia has the same concern as other African countries which is to ensure that a well-functioning health system is available to promote the health and social well-being of all Namibians (MOHSS 2004a:1).

1.2.1 Country profile

Namibia, with a surface area of 824 116 square km, is the fifth largest country in Africa. It is located in the south western part of the continent and it is bordered by the Atlantic Ocean in the west, Botswana and Zimbabwe in the east, South Africa in the south, and Angola and Zambia in the north. The country is divided into 13 administrative regions and 34 health districts.

The total population of Namibia is about 1.8 million, with a growth rate of 2.6% and a population density of 2.2 persons per square km. While Namibia has achieved major gains in reducing mortality among children over the past ten years, life expectancy in other age groups has not improved. The HIV/AIDS epidemic has caused a massive decline in life expectancy, which in 1991 was 59.1 years for men and 62.8 years for women, but dropped to 47.6 and 50.2 years in 2001 (MOHSS 2004a:2; GON 1995:1; UNDP 2000:2).

1.2.2 Socio-economic features

Namibia, with a per capita income of US$ 1890, is classified as a lower middle-income country (MOHSS 2003:5). The per capita income exceeds that

for sub-Saharan Africa (US$ 500) as well as that of other lower middle-income countries (US$ 1200). The economy is mainly dependent on the export of primary commodities such as diamonds, uranium and gold (MOHSS 2003:5).

The main economic challenges remain redressing the inequalities in income and welfare and reducing the high levels of poverty. The government is relentlessly working through its various policies and interventions towards ameliorating the magnitude of these problems. Emphasis is given to these problems in the Second National Development Plan, the National Poverty Reduction Action Programme and Vision 2030. Given the current state of the economy, rectification of these difficulties needs some time (MOHSS 2003:6).

1.2.3 Epidemiological profile

Communicable diseases account for the greatest proportion of the disease burden. Diseases such as HIV/AIDS, tuberculosis and malaria have a relatively high incidence. The prevalence of HIV/AIDS in 2001 was estimated at about 20% of the population. Likewise, tuberculosis is on the increase, due partly to its association with HIV/AIDS. In 2001, the incidence rate of tuberculosis was estimated at 680 per 100 000 population. Malaria is also posing a major problem. The five main causes of mortality in public health facilities are: HIV/AIDS (15%), pulmonary tuberculosis (13%), diarrhoea (12%), malaria (11%) and pneumonia (8%). The main causes of morbidity include diarrhoea (8%), tuberculosis (6%), HIV/AIDS (5%) and malaria (4%) during the 2001/02 financial year (MOHSS 2004a:2). Non-communicable

diseases are also increasing. Hospital statistics indicate that cancer and cardiovascular disease are among the main causes of death. This creates an additional burden for the health system which is already over-stretched.

1.2.4 Organization of services

Namibia's health policy is based on the principles of primary health care that include equity, community involvement and intersectoral collaboration. The MOHSS plays the stewardship role as it is entrusted with the formulation of policies and strategic plans, mobilization of resources and allocation of external relations. Figure 1.1 illustrates the administrative regions with the 13 Regional Management Teams that oversee service delivery in a total of 34 health districts. Clinics (259) are the main entry points in the delivery of health services, although there are 1150 outreach points. Other health facilities include 37 health centres, 30 district hospitals, three intermediate hospitals and one national referral hospital (MOHSS 2004a:3).

The Namibian health sector has a well-established private for-profit component. Private hospitals provide services in the main urban centres. There are a number of private not-for-profit health services, mostly in the rural areas, run by missionaries.

These are almost fully subsidized by the government. In addition, the mining sector provides health services to the surrounding communities. Traditional

healers and the community's own resource persons such as traditional birth attendants are other categories of health providers (MOHSS 2003:3).

Figure 1.1: Administrative regions of the Republic of Namibia

Source: MOHSS (2000b:8)

1.2.5 Health financing

The total expenditure on health is about 7.5% of the GDP—one of the highest in sub-Saharan Africa. Health is thus one of the priority sectors, which receives a relatively higher share of public funds. During the 1993-2000

period, about 11% of government spending was earmarked for health (MOHSS 2003:8).

1.2.6 Development of human resources for health

With regard to human resources development and management, the National Health Policy Framework stipulates various procedures. For example, a long-term human resources strategic plan should include pre-service training, and retraining and development of existing staff members to address the priority health and social problems in an appropriate and integrated manner. Secondly, the standard of professional practice and code of conduct for all categories of health and social welfare personnel should be maintained and improved where necessary to compare with international standards. Available staff should be deployed and redeployed according to appropriate staff utilization rates (MOHSS 1998:3; MOHSS 2004b:8).

The main human resources for health issues and challenges identified include the imbalances in the geographical distribution of human resources for health (shortages in rural areas in comparison with urban areas); inequalities in available skills, especially at district level; poor human resource management, information systems and evidence to support planning and decision-making processes; lack of management skills at all levels; movement of health workers from public to private sector; the public outcry about poor performance of health personnel resulting in poor quality of services; negative attitude and low motivation of health workers; and a general feeling

of despondency among health workers due to limited opportunities for career advancement and performance reward systems (WHO 2000:1).

To address these challenges, the National Human Resources for Health Strategic Plan was developed (MOHSS 2000a:1). It identified insufficient trained health personnel, especially the lack of management skills at all levels of health care, as the main constraint in the provision of effective health care services delivery. Another challenge is providing health care to the widely-dispersed population. Producing well-motivated and skilled health personnel is complicated by the emergence of HIV/AIDS as a disease affecting the economically-active populations in sub-Saharan Africa. Namibia is among the most affected countries in southern Africa, with a prevalence rate which increased from 4% in 1992 to 22.5% in 2001 (WHO 2004:2).

McCourt and Awases (2005:2) conducted a survey on innovative approaches and promising practices for improving the management of the health workforce in Namibia. A wide range of health workers, including nursing managers and nurses deployed in health facilities at regional and district level, were interviewed. The interviews also included the staff at the Office of the Prime Minister.

The interviews assessed approaches and practices for recruitment and retention, training, productivity and performance of staff. Focus group discussions held with hospital and clinic staff at the regional and district level

showed that as much as heroic dedication, staff are often exhausted and demoralized as captured below:

> *"You get so demotivated because you're doing the same thing all the time, but have no time to ask patients if they are really OK. In the old days – five years ago – TB patients were healthy, just needing medication once a day. Now they need to be bathed, turned" (ward nurse).*

The complaint was mainly about increased workload due to low staff numbers. Nurses felt that they do not get recognition for their work, and qualifications acquired through distance education were not recognized. Interviews revealed that nurses working at the health centres felt that they do not get the necessary assistance from the MOHSS and said,

> *"Clients come and criticize us that we are slow and only standing around and doing nothing*. *They complain right in your face, even if they can see that the queues are long and we are doing everything we can do to see everyone. They also complain on the radio and TV chat shows".*

Another nurse stated *"We are working under stress here. We see up to 100 clients per person each. Truly speaking our examinations are not 100% because we rush to finish the long queue".*

There is no performance appraisal system in place because the previous system was abandoned in 1998 (McCourt & Awases 2005:7). Despite these difficulties, there is a sense of professional pride and sense of vocation when they were asked what motivates them to stay and provide health care, the answers ranged from *"I am here to serve the nation", "I love the people that I nurse" to "If someone recovers, a patient, you are very happy"*. Others said that the opportunities they got to attend workshops and training courses motivate them to stay. Other outstanding motivating factors were good working benefits in the public sector, including housing allowances, medical coverage and pension scheme (McCourt & Awases 2005:12-13).

It is important for employers to ensure that the performance of employees is of a high standard; if this is not the case, measures should be put in place to detect and rectify the situation. It is important to improve the level of performance of first-line health workers or those who are continuously in contact with the clients, community and patients at all levels of health care.

The most recent information on nursing posts in the country is that nurses make up the largest number of health workers in the public sector and are estimated at 2848 registered professional nurses and 2043 enrolled nurses compared to 666 medical doctors and 288 pharmacists (WHO 2005d:1). This means that the country relies heavily on nurses for service delivery; their performance, therefore, is critical for the successful provision of health care. This study, therefore, focuses on identifying factors that affect the performance of professional nurses in Namibia.

It is against this background that this study on performance is proposed. The factors affecting performance of nurses have not yet been examined in Namibia. In fact, this subject has not previously been thoroughly studied in Africa. There is a need to seek evidence about the performance of nurses and find ways to monitor and improve their performance. The study focuses on nurses working in the various health facilities in Namibia.

1. 3 PROBLEM STATEMENT AND RESEARCH QUESTIONS

Health care delivery is highly labour-intensive. The quality, efficiency and equity of services are all dependent on the availability of skilled and competent health professionals when and where they are needed. It is essential that health workers are appropriately trained to deliver the required services at a high standard.

The available literature consistently reports that African health workers are dissatisfied and demotivated with the current situation (Awases et al 2004:53; WHO 2003a:18). Many countries reported a decline in quality of health services, and long queues of clients and patients waiting to be seen (Awases et al 2004:58). The same was revealed during interviews with nurses and health centre staff in both the capital and districts in Namibia which showed that the nurses, who are supposed to be the backbone of health services, are

overworked and demoralized. They show signs of burnout and complain of non recognition of the contribution they are making.

There is a growing concern about the poor quality of health services rendered to the population, even though the MOHSS policy endeavours to advocate for improved quality of services to be provided at health facilities in the country. Furthermore, it is clear that nurses have a major role to play in the provision of timely and quality health services for many years to come. During interviews at the Office of the Prime Minister, it was revealed that a new performance appraisal system is eminent which should motivate public servants in line Ministries to improve performance of staff.

The issues of performance and factors affecting performance are not adequately addressed in Namibia. Therefore, it is necessary to generate relevant evidence through a detailed study to guide the MOHSS and other health partners to develop strategies for improving the performance of heath workers. The obvious solution is to develop strategies that will monitor the performance of nurses and suggest ways of improving their motivation and subsequently their performance. The evidence from this study could feed into the new performance appraisal system being developed.

In response to these concerns, a study is proposed to answer these questions:

- Which factors affect the performance of professional nurses both positively and negatively?
- Are nurse managers equipped to facilitate good performance of their subordinates?
- Which strategies could be suggested to increase the performance of professional nurses?

1. 4 AIM AND OBJECTIVES

The study aims at providing a human resources management framework that can be used to monitor and manage changes in nurses' performance so as to improve the performance of professional nurses in Namibia.

The objectives of this study are to:

- Determine factors which positively and negatively affect the performance of professional nurses;
- Ascertain the skills and competencies of nurse managers in order to facilitate good performance by their subordinates;
- Propose strategies that could improve performance of professional nurses;

1. 5 SIGNIFICANCE OF THE PROBLEM

According to Homedes and Ugalde (2004:1), human resources or the health workforce are the most important assets of health systems. There are many complex reasons for the deterioration of health systems in the African region; however, the main cause is the neglect of the health workforce (High-Level Forum on MDGs 2004:2). The human resource capacity in developing countries is insufficient to absorb and deliver health interventions offered by many new health initiatives such as the millennium development goals.

According to Sullivan (1998:2), development partners formerly believed that training was the best way to improve performance. However, over the years it has been recognised that sustainable performance improvement depends on a number of factors, including clear job expectations, goals, organizational culture, performance standards, performance feedback, provider-employee relationships, knowledge and skills, supervision and management support, as well as the working environment (Sullivan 1998:3; Fort & Voltero 2004:4).

Fort and Voltero (2004:6) identify measurement and evaluation of performance as keys to improving performance. They further identify key aspects of performance:

- standardization of care by describing what is the expected or desired performance (standard of care)
- determining if interventions are reducing the gap (measurement) so as to contribute to the achievement of the goal (performance outcome).

Nursing staff is the largest personnel component in the public health sector and are deployed at all levels of the health care delivery system. This study is important because no previous research has been documented in Namibia concerning factors affecting the performance of professional nurses. In addition, the Public Service Commission, which is the employer of all public servants, and is tasked with developing performance appraisal systems in Namibia, discontinued the government staff appraisal system in 1998; hence, the health workforce, including nursing personnel, is left without a formal system of assessing performance, acknowledging efforts or constructing measures to redress performance gaps. In view of the current demands on nursing personnel at health facilities to provide timely and quality health services, a supportive performance system which could contribute to the enhancement and improvement of the performance of professional nurses would be of great value.

This study should support nurses in management positions and professional nurses to identify factors that affect performance. It should also encourage and motivate them to improve the overall performance of nursing personnel to contribute to the achievement of organizational goals.

1.6 STUDY FOCUS AREA

Performance of health workers will be determined by assessing the performance of professional nurses in selected health facilities at tertiary, intermediate and private hospitals in the Khomas region. Two categories will be included: The first group includes nursing service managers of health facilities as well as those responsible for managing wards. The second group includes subordinates which are also professional nursing staff working in wards under the supervision of a nurse ward manager or senior professional nurses in charge of a ward.

1.7 THEORETICAL FRAMEWORK

Bennett and Franco (1999:4) proposed a conceptual framework of factors that influence work motivation. Figure 1.2 depicts a complex web of links and interaction between work motivation, performance, and organizational factors within the health sector environment:

- *Workers' individual needs factors* such as goals, self-concepts, expectation, worker capability and worker experience of outcomes are some of the individual's determinants of motivation.
- *T*he *organizational factors and systems* in which the worker is operating with inputs such as drugs, supplies, support and feedback will affect the outcomes of performance.

- The *broader social and cultural* factors which is outside the organizational environment which include issues such as the interaction between health worker and the client, the expectations from the community on how health care services should be delivered may affect motivation for performance.

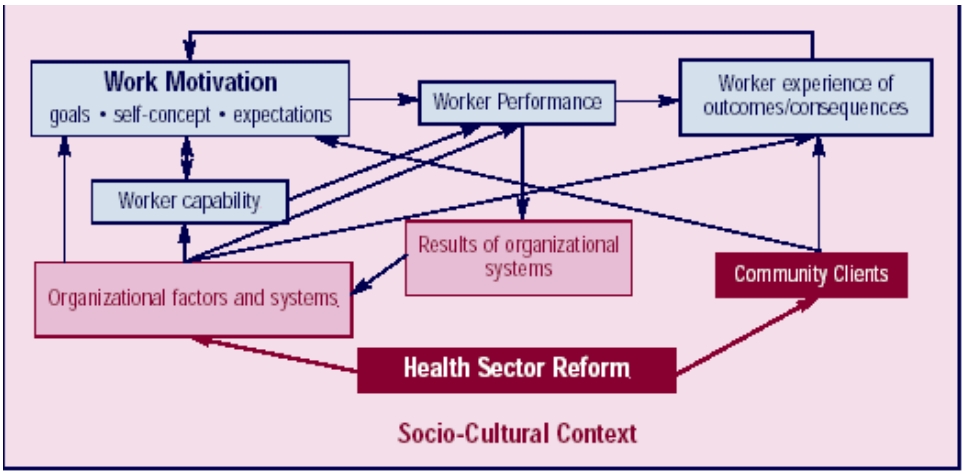

Fig. 1.2: Work motivation in larger societal health sector context

Source: Bennett & Franco (1999:5)

The interconnection between social, individual and organizational factors has been recognised as a dimension of performance. According to Bennett and Franco (1999:4), the role of the organization is to communicate its goals, as well as the processes and resources for achieving these goals; additional goals are to put in place a system of feedback and to develop staff knowledge and skills.

Bennett, Franco, Kanfer and Stubblebine (2001:1) mentioned that problems of low motivation identified in developing countries, results in lack of courtesy to patients, high level of absenteeism and poor quality of health care such as poor patient examination and failure to provide timely treatment to patients.

Sharpley (2002:3), on the other hand, proposes a model, as depicted in figure 1.3, that identifies individual perceptions (self belief, anticipating success and critical thinking), experience of work (personal impact, competency, meaningful work, feedback, and discretion) and work outcomes (job satisfaction, work stress, empowerment and motivation) as differences in individuals that affect their experience at work.

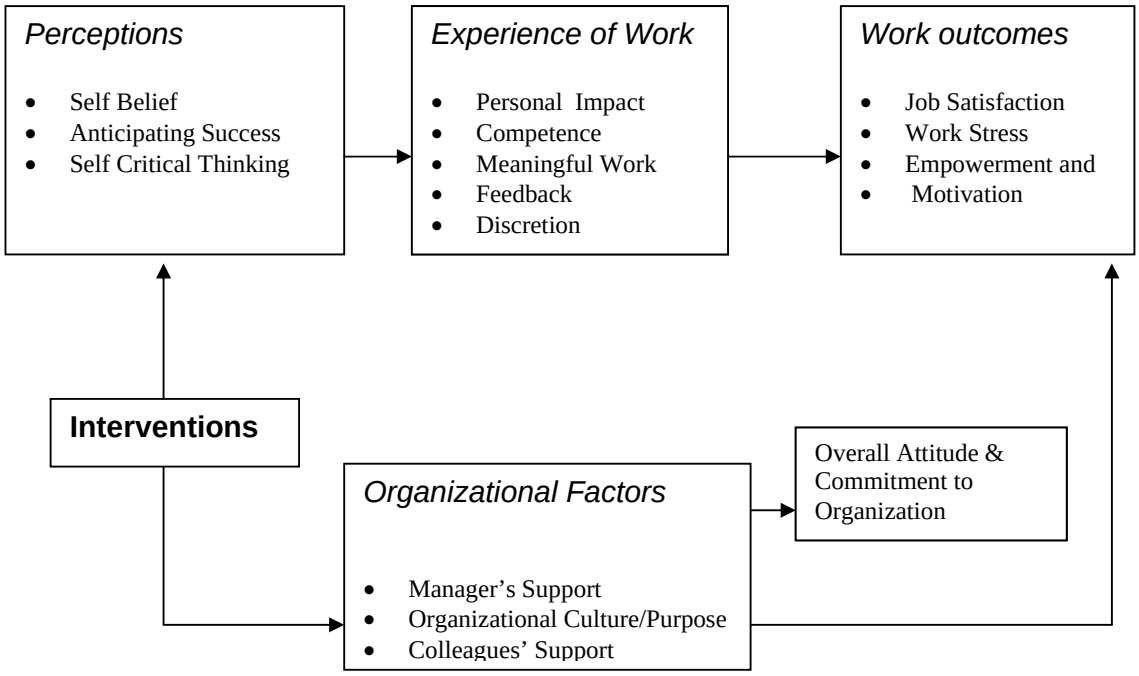

Figure 1.3: The perception, motivation and performance model
Source: Sharpley (2002:2)

In addition, organizational factors such as managerial support, colleague support and organizational culture are associated with high performance.

According to him, interventions depend on all the above mentioned factors as well as the overall attitude and commitments by the organization which will eventually lead to the achievement of organizational goals.

Flanagan and Henry (1994:23) stress the notion of a healthy working environment as the responsibility of an organization, which should create and provide conditions conducive to good health and high performance. In other words, performance depends on whether staff perceives themselves as capable, whether they are willing to perform and whether they have the means to achieve.

Nickols (2003:2-3) and Fort and Voltero (2004:3) identify similar factors that are closely related and affect provider performance in the workplace. They include clear goals and job expectations, suitable repertoire, immediate feedback, skills to perform, knowledge of the organizational structure, functional feedback system, sound mental models, sufficient motivation through self-satisfaction and incentives, supportive or conducive environment, and manageable tasks.

For the purpose of this study, a combination of the conceptual framework of Bennett and Franco (1999) and the model of Sharpley (2002) will be used as

the theoretical basis on which this study is based and will be called the Performance Model illustrated in figure 1.4. This model consists of the following:

- *Social factors* that include expectations from the community, social values, and cultural beliefs;

- *Individual factors* that include issues of individual perception, experience of work and individual work outcomes; and

- *Organizational factors* which include issues of performance management style, strategic coherence, norms and standards, communication, supervision and reward.

The Performance Model will guide the study as well as the development of a framework for monitoring and improvement of performance of nurses.
According to this model, the variables and processes affecting performance of nurses would include job expectations or design; goals and objectives;

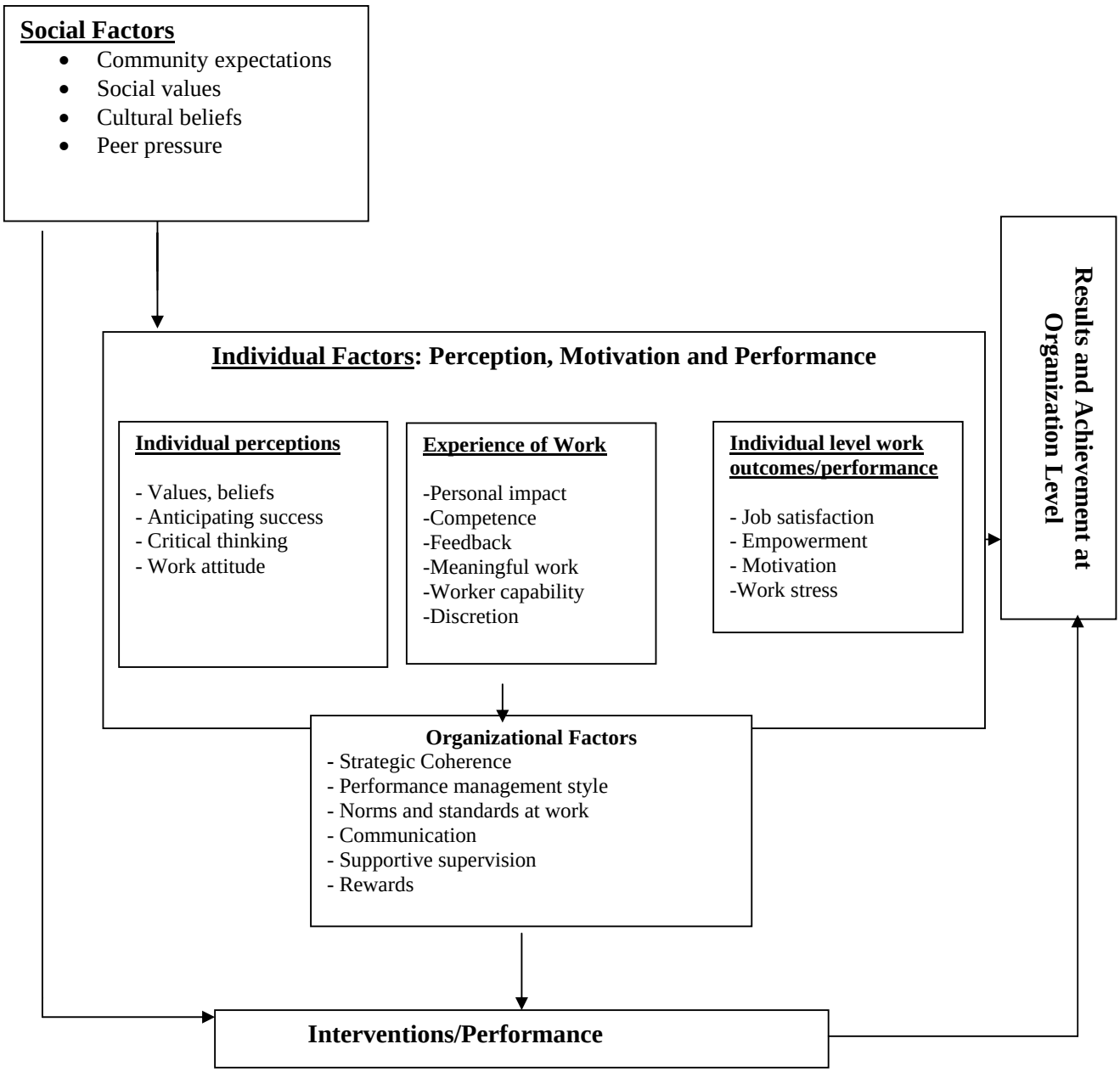

Figure 1.4: The performance model (adapted from Bennett & Franco (1999:4-5) and Sharpley (2002:2)

organizational culture and support; management style, feedback and communication; and the physical environment. Intrinsic factors such as

motivation, self-perception, values and beliefs, incentives, rewards and employee benefits, knowledge and skills are also important.

1.8 RESEARCH METHODOLOGY

Research methodology refers to "…Techniques used to structure a study and gather and analyse information in a systematic way" (Polit & Beck 2004:731). The methods used are described comprehensively, including the context in which the data collection took place particularly the relationship between the research question and data collected (De Vos, Strydom, Fouche & Delport 2005: 252).

1.8.1 Research Design

The study followed a quantitative research model using an explorative and descriptive design. **Quantitative** is a process in which numerical data is used to obtain information and consist of descriptive, correlation, experimental and quasi-experimental research. **Descriptive** research is the exploration and description of phenomena in real situations. It allows the researcher to generate new knowledge of the subject by describing characteristics of persons, situations and the frequency with which certain phenomena occur (Burns & Grove 1993:37). The **exploratory** design will allow the use of questionnaires to a large sample of the population and is therefore intent on

finding facts which relate to the field of study (Couchman & Dawson 1995:40). Exploratory research probes more by allowing for an in-depth exploration of dimensions of the phenomenon, including its manifestation and related factors (Polit & Hungler 1989:19; Enarson, Kennedy, Miller & Bakke 2001:37).

A survey method of data collection through questionnaires was used. According to Varkevisser, Pathmanathan and Brownlee (1991:148), the advantage of this method is that it is less expensive, permits anonymity and may result in more honest responses. Another advantage is that the researcher does not have to be present; this eliminates bias due to phrasing questions differently for different respondents.

1.8.2 Population and sample

According the Polit and Hungler (1989:169), "...Sampling refers to the process of selecting a portion of the population to represent the entire population". A population is an entire aggregation or eligible group from which a sample can be drawn. The accessible population "… is the aggregate of cases that conform to the designated criteria and that are accessible as a pool of subjects". The target population "…is the aggregate of cases about which the researcher would like to make generalizations (Polit & Beck 2004:290). Sampling therefore involves selection of a number of units from a defined study population. The representative sample consists of subsets of the elements of a population; this allows for study results to be generalized. The

characteristics of the sample population are intended to be representative of the target population.

A stratified random sampling method was used in this study whereby the population was divided into two strata, one consisting of professional nurses and the other consisting of professional nurses who are supervisors or in management positions referred to in the study as nurse managers.

The target population for this study included all professional nurses employed in the Oshana, Otjozondjupa and Khomas region. The accessible population includes all professional nurses working in selected hospitals which included one national referral hospital, two intermediate or regional hospitals, one district hospital and one private hospital in the above mentioned regions.

The study included two groups of hospitals: those with more than 450 beds and those with just over 100 beds. Those with more than 450 beds provided responses from a large number of nurses in teaching hospital situations.

1.8.3 Data collection instruments

According to Enarson et al (2001:73), questionnaires are often used for recording data. Well-designed questionnaires should collect accurate and reliable information. The advantage of questionnaires is that they are simple and relatively inexpensive and can provide information from large numbers of

subjects. The disadvantage is that they depend on personal reporting and therefore may be biased or inaccurate (Enarson et al 2001:79). A structured self-administered questionnaire was designed for collecting and recording data. The design of the questionnaire was guided by the objectives of the study and the literature research; it included open-ended and closed questions.

Validity refers to "…the degree to which an instrument measures what it is supposed to be measuring" (Polit & Hungler 1989:246). Varkevisser et al (1991:151) and Polit and Hungler (1989:246) identify three approaches for establishing the validity of instruments designed to collect quantitative data: *Content validity, criterion-related validity* and *construct validity*. Content validity refers to how relevant the questions are to the subject under study. In this study, the content validity of instruments was ensured by including all the key concepts relevant to the research topic. The questions were formulated according to the components of the Performance Model.

Reliability of an instrument can be equated to *clarity, stability, consistency* and *accuracy* of a measuring tool (Polit & Hungler 1989:242; Varkevisser et al 1991:152). According to Polit and Hungler (1989:242), various methods exist for assessing the stability aspect which concerns the extent to which a questionnaire will provide the same results on repeated administration. *Internal consistency* reliability refers to the extent to which all the subparts of an instrument will measure attributes. The Cronbach's Alpha test was used to test internal consistency of the instruments.

1.8.4 Data analysis

Data analysis refer to "…the systematic organization and synthesis of research data, and the testing of research hypothesis" (De Vos et al 2005:716). Data analysis gave meaning to data collected during research (Burns & Grove 2003:479).

According to Varkevisser et al (1991:241), it is important to design a processing and analysis plan which should include issues such as sorting of data, performing a quality control check, data processing and data analysis. The SPSS computer programme was used to analyze the results. Descriptive statistics that include frequencies and percentages are used.

1.9 PILOT STUDY

According to Burns and Grove (2003:42) a pilot study is often defined as "…a smaller version of a proposed study, and is conducted to refine the methodology" The pilot study help to identify possible problems in the proposed study and allows the researcher to revise the methods and instruments before the actual study (De Vos et al 2005: 206; Varkevisser et al 1991:265).

Pilot testing is also used in field-testing a research instrument, such as a questionnaire before applying the final instrument (De Vos et al 2005:209). A pilot study was carried out in two hospitals.

1.10 PERMISSION TO CONDUCT RESEARCH

Permission was acquired from the Permanent Secretary, Ministry of Health and Social Services, as well as the management of the private hospital. Upon receiving permission from the Permanent Secretary, a letter was forwarded to the concerned public hospitals to request their permission for data collection.

1.11 ETHICAL CONSIDERATIONS

Ethics is mostly associated with morality and deals with issues of right and wrong among groups**,** society or communities. It is therefore important that everyone who is dealing or involved in research should be aware of the ethical concerns (Babbie 2005: 61).

Efforts were made to avoid as far as possible violation of ethical principles. Basic principles guiding ethical considerations for research includes respondents being fully informed about the aims, methods and benefits of the research, granting of consent and voluntarily to participate in the research (Enarson et al 2001:133). Babbie (2005:61) stressed the importance of

ensuring anonymity of the respondents and the protection against any physical or physiological harm. A covering letter explaining the aim and objectives of the study and stressing that confidentiality will be maintained with regard to the information provided and anonymity of respondent, accompanied each questionnaire.

1.12 LIMITATION OF THE STUDY

The limitation of the study was that the private hospital may not grant permission for the study to be conducted and that not all questions are clear and relevant. Caution was taken during the construction of the questionnaires to ensure that the questionnaire items are clear, unambiguous and elicit the intended data. According to Polit and Hungler (1989: 22) Babbie (2005:254), virtually all research studies contain some flaws.

1.13 DEFINITION OF TERMS

The following terms are relevant to this study.

Benchmarking: Is the process of comparing one's performance with the best performance to become the "best of the best". The basis for comparison shifts from within the organization to outside the organization (WHO 2000:47).

Competency: Skill, knowledge and attitude acquired through training, education and experience, and performed to specific standards under specific conditions.

***Human Resources for Health*:** Human resources for health (HRH) or health workers are defined as “All persons working in health service delivery including: private practices and health-related institutions, plus personnel working in units that supply medical or related aids for people with disabilities, staff in the administration of a health sector, health information system, health ministry staff and the respective staff developing and producing health products like drugs, aids, spectacles, and supplies or equipment for health care units like beds and technical equipment, as well as teaching staff, students, catering and maintenance staff (WHO 2000 :1).

Human Resources Management (HRM) refers to mobilization, motivation, development, and fulfilment of human beings in and through work and covers all matters related to the employment, use, deployment and motivation of all categories of health workers, and largely determines the productivity, and therefore the coverage, of the health services system and its capacity to retain staff.

Outcome measurement is any measurement system used to uncover or identify the health outcome of treatment of a patient, or at a systems level, for example, outcome of a set performance standard (WHO 2000:47).

***Performance*:** Perform means “to carry out, accomplish or fulfil an action or task”. It also means “work, function or to do something to a specific standard”. Performance is “an action or process of performing a task or function” (Oxford Concise Dictionary 1999:1060). Important variables to be kept in mind are function, work, action, task, process and specific standard. Performance is the actual conducting of activities to meet responsibilities according to standards. It is an indication of what is done and how well it is done (Winch, Bhattacharyya, Debay, Sarriot, Bertoli & Morrow 2003:2).

Performance appraisal means the observation and assessment of employee performance against pre-agreed and pre-established activities and standards.

Performance management in the context of staff management it “is about helping people to work more effectively by improving individual and team performance, increasing the overall productivity of an agency” (PSMPC 2000:1).

Professional nurse: A person registered with the nurse regulatory and registering authority of their country. Professional nurses are trained at higher education level with the training period between 3-4 years. Professional nurses are also called registered nurses working in clinical, nursing services and educational institutions.

Skill is the ability to perform a task or a group of tasks which often requires the use of motor functions but also specific knowledge and skills.

***Standards of quality*:** Authoritative statements of the minimum levels of acceptable performance or results and excellence levels of results, or the range of acceptable performance results. Standards can be based on scientific knowledge and professional consensus. Standards of conduct and ethical standards are based on social consensus (WHO 2000:47).

Work environment: Characteristics of the environment in which a person is expected to work. Includes physical and social environment, employment conditions and benefits.

Workforce: People who work in the various professions of health care, that is doctors, nurses, midwives, pharmacists, dentists, allied health workers, community health workers, paramedics, whose goal is to improve the health of the populations they serve.

1. 14 ORGANIZATION OF PROPOSED STUDY

The outlay of the research report will include the following chapters:

Chapter 1: Introduction and orientation to the study: The issues concerning performance of nursing personnel in Namibia were discussed. Also, the aim and objectives, theoretical framework and relevance of the study are included and the relevant terminology is clarified.

Chapter 2: Literature Review: A literature review of relevant articles, journals, books, research reports and other information sources was conducted with the aim of establishing and identifying available knowledge and evidence on factors affecting the performance of professional nurses. Information sought include issues related to human resources management, performance management systems, including performance appraisals as well as aspects related to knowledge and skills, management skills and leadership.

Chapter 3: Research Methodology: Research design and techniques are explained. Detailed information about the population and sample, instrumentation used, methods for data collection and analysis were presented.

Chapter 4: Analysis of data with regard to the questionnaires are presented.

Chapter 5: Conclusions and Recommendations: Results are discussed and compared; conclusions were derived from the results. Recommendations and suggestions for further studies are outlined and a framework for developing and improving of performance is proposed.

1.15 CONCLUSION

An overview of the health care delivery systems and the human resources for health situation in Namibia led to the development of the research questions,

assumptions and aim of the study. A theoretical framework, relevant to the issues affecting performance of health workers was identified. Furthermore the demarcation of the field of the study as well as study format was discussed. The next chapter will deal with the literature review.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Health-care delivery is highly labour-intensive. The quality, efficiency and equity of services are dependent on the availability of skilled and competent health professionals when and where they are needed. It is essential that health workers be appropriately trained to deliver the required services according to set standards. Due to critical shortages of certain key health workers, the challenge to health authorities is to ensure that the available health workers are appropriately skilled and motivated to provide effective health-care services to populations living in a vast geographical area. It is important now, more than ever, to assess the factors that positively and negatively affect the performance of health workers to ensure that they are optimally utilised.

This study aims at eventually providing a human resources framework that can be used to monitor and manage changes in nurses' performance so as to improve the performance of professional nurses in Namibia.

This chapter consists of a literature review discussing various factors. The review aimed at identifying, clarifying and establishing factors and related issues that may affect positively or negatively the performance of nursing staff in organizations. It was found that literature focusing specifically on factors affecting the performance of health workers in health settings, and particularly

nursing personnel, was limited. Some of the factors appear as part of research topics, papers and journals and were found to be pivotal and important. The literature review therefore looked at performance of staff from a general perspective. Specific attention was focused on the following areas:

- Analysing the various conceptual frameworks and models that focus on factors and related issues that affect motivation and subsequently the performance of staff;

- Information on human resources for health management and development issues, including various models and policy issues;

- Various aspects of assessment and monitoring of performance of staff in an organization;

- Management competencies for directing and guiding the performance improvement of health workers.

The theoretical framework forms the basis of the study and will be discussed next.

2.2 THEORETICAL FRAMEWORK

Burns and Grove (2003:155) define a theory as "… an integrated set of defined concepts and statements that present a view of a phenomenon and can be used to do one or more of the following: describe, explain, predict, or control the phenomenon". Conceptual models are similar to, but more abstract than theories; each model "...broadly explains phenomena of interest, expresses assumptions, and reflects a philosophical stance" (Burns & Grove 2003:155).

A number of models that refers to factors related to performance of staff have been identified. Two are particularly important, namely:

- Bennett and Franco's model on factors that influence work motivation in a health sector context, and
- Sharpley's perception, motivation and performance model.

2.2.1 The Bennett and Franco's model on work motivation

Bennett and Franco (1999:4) proposed a conceptual framework of factors that influence work motivation; the factors are identified as individual, organizational, broader social and cultural factors. This model, as illustrated in Figure 1.2, focuses on motivation as the main factor that influences the level of performance of health workers.

2.2.1.1 Individual or internal motivation process

The individual or internal level is described as a process in which various determinants such as the workers' needs, self-concept, expectation and perceptions about own work capability may lead to performance outcome. The organization, on the other hand, should provide the necessary inputs such as supplies and logistics, as well as an efficient supportive system and environment for the worker to influence motivation that will trigger good performance (Bennett & Franco 1999:4). The outcomes of motivation are mainly affective (perception, or what workers feel about their work), cognitive (what they think) and behavioural (what they do) (Bennett & Franco 1999:7).

2.2.1.2 Social and cultural factors

The Bennett and Franco framework emphasises the fact that apart from internal factors, there are a number of other complex factors that significantly influence motivation. These are social and cultural factors and include issues such as community expectations, peer pressure or social values of health workers and health managers which may also contribute to an individual's motivation to work. The reason is that individuals are part of a larger community and may reflect the cultural beliefs of that particular community which may be in conflict with those of the organization; individuals' values are assumptions of their community in the workplace. Wider cultural values may translate into specific types of work behaviour that clash with certain organizational policies. Individual

workers whose values do not correspond to those of the organization may be less willing to personally commit to the organization (Bennett & Franco 1999:17).

2.2.1.3 Organizational factors

Organizational factors that are linked to the day-to-day environment in which health workers carry out their duties and which may affect the level of performance include aspects of internal organizational structure such as clearly-articulated goals, the human resources management style, information with regard to norms and standards, and support to the employee. Issues such as delegation of authority, autonomy in undertaking tasks, supervision, systems of feedback, and availability of resources also affect staff motivation (Bennett & Franco 1999:8).

The interconnection between the social, individual and organizational factors has been recognised as a dimension of motivation that can eventually affect performance. According to Bennett and Franco (1999:4), the role of the organization is to communicate its goals, the processes and resources for achieving these goals; additional goals are to establish a system of feedback and to develop staff knowledge and skills.

Other authors seem to agree to some extent with Bennett and Franco's model. For instance Zurn, Dolea and Stilwell (2004:3), support the notion that

motivation at work is *generally* believed to be a key factor in individual performance. They acknowledge that *evidence* supports the *connection* between job dissatisfaction, lack of motivation and intention to quit. They also stressed that since health care delivery is highly labour-intensive, health service quality as well as efficient and equitable distribution therefore will depend on health workers' willingness and ability to commit themselves to their tasks.

Zurn et al (2004:3) distinguish between three factors that are believed to play a key role in performance of health workers and are similar to Bennett and Franco's conceptual framework of factors that influence work motivation. They are:

- Capability of staff to attend to their jobs (knowledge, skills and experience);
- Motivation of staff to put effort into their work;
- Organizational support (resources and policies) and opportunities, including a physical and social environment conducive to work.

2.2.2 Sharpley's model on perception, motivation and performance

Sharpley (2002:2) proposed a model, as depicted in Figure 1.3, that is centred around three individual factors as the most important affecting the interventions of health workers. These factors are seen as the differences in individuals that affect their experience at work. These differences are:

- Perceptions - self-belief, anticipation of success and critical thinking;

- Experience of work - personal impact, meaningful work, feedback, and discretion;
- Work outcomes - job satisfaction, work stress, empowerment and motivation.

Organizational factors are equally important and support the interventions of individuals. The Sharpley model also considers organizational factors such as managerial support; colleague and supervisor support as well as organizational culture associated with high performance.

Sharpley sees individual perceptions, individual experience of work and work outcomes or achievements as important for work motivation and positive performance. According to him, differences in individuals affect their perceptions and are significantly linked to work demand. The manner in which individuals react differently to work demand, setbacks or disappointments is important and should be considered in order to get insight into issues that affect motivation and performance (Sharpley 2002:3).

According to Sharpley (2002:4) the most important aspect of high performance is the appreciation of one's role, i.e. understanding and knowledge of the different processes of individual or manager roles.

2.2.3 The Performance Model

For the purpose of this study, a combination of the conceptual framework of Bennett and Franco (1999) and the model of Sharpley (2002) will be used as the theoretical base. It will be called the *Performance Model,* as illustrated in Figure 1.4, and will consider the following dependent factors:

- *Social factors* which include expectation from the community, peer pressure, cultural beliefs and social values;
- *Individual factors* that include issues of individual perception (values, beliefs, critical thinking, anticipation of success and work attitude), experience of work (needs, self-concept, personal impact, skills competence, feedback, incentives and rewards) and individual work outcomes (job satisfaction, empowerment, motivation, worker capability and achievement);
- *Organizational factors* that include issues of managers' support and performance management, organizational culture, norms and standards used at work, communication, supervisor and colleague support. All of these factors affect the capability of health workers to perform a certain task positively or negatively (Bennett & Franco 1999:2; Sharpley 2002:2).

Nickols (2003:2) and Fort and Voltero (2004:3) identify similar factors that are closely related and affect provider performance in the workplace as indicated by the Performance Model. They include e clear goals and job expectations,

suitable repertoire, immediate feedback, skills to perform, knowledge of the organizational structure, functional feedback system, sound mental models, sufficient motivation through self-satisfaction and incentives, supportive or conducive environment, and manageable tasks.

The Performance Model will guide the study and the development of strategies and a framework for enhancing the performance of health workers. According to this model, the variables and processes affecting performance of health workers would include job expectations or design; goals and objectives; organizational culture and support; management style, feedback and communication; and the physical environment. Intrinsic factors, such as motivation, self-perception, values and beliefs, incentives, rewards and employee benefits, knowledge and skills, are also important.

According to Price (2000:8), four key factors are important for an organization to operate effectively. They include:

- Strong, goal-oriented leadership;
- High levels of employee motivation and skills;
- Holistic approach to management and organizational change;
- Perception that employees are regarded as valuable human capital.

Rafferty, Maben, West and Robinson (2005:31) and Mutizwa-Mangiza (1998:10) emphasise that environmental and organizational factors may negatively or positively affect performance of health workers. Environmental or external factors include political pressure and health-care reforms, financial

pressure, decentralisation of health-care systems, client/user pressure, and quality assurance and changes in health professional education. Organizational or internal factors include human resources management systems (for example, effective planning, policy, skills mix, industrial relations, and skill retention), focused team work, organizational structure, management skills, performance standards, norms and values. Other internal factors include performance appraisal systems, input by all stakeholders in regulatory and policy procedure development, mutual supportive relationship, salary and incentive structure, sufficient staff and equipment, personnel and career development.

The theoretical frameworks and Performance Model distinguish various individual, organizational and social factors that may in various ways affect the performance of health workers. It can be assumed that the critical functions of an organization are identifying the factors that impact on performance and seeking solutions and innovative initiatives that empower staff and boost performance. Nogueira and de Santana (2003:74) emphasise that it is important for organizations to put in place sound human resources management systems, provide necessary policy and regulatory frameworks and ensure conducive working environments for health workers.

2.3. HUMAN RESOURCES MANAGEMENT

Human resources management deals with the aspect of managing people in a strategic, coherent and integrated way. According to Swansburg and

Swansburg (1999:3), *management* "...means accomplishing the goals of the group through effective efficient use of resources", and "...*managing* is the art of doing" while "...management is the body of organised knowledge underlying the art".

Human resources or *people* are the most valuable assets of an organization. They are the ones that make things happen, and they influence all inputs in an organization, whether they are managerial or operational (Hendry 1995:5).

Human resources management includes all processes that affect the relationship between an organization and its employees and is geared towards achieving the organization's objectives (Price 2000:5). Human resources management is also seen as a political regulatory function that mediates between a bureaucracy and the ethical and political goals embedded within an organization's mission (Nogueira & de Santana 2003: 85).

Human resources management's political role of regulation is important for two reasons: firstly, it satisfies the legal requirements for the different elements of human resources management systems which are planned according to the organization's missions. And secondly, within the organization, human resources are mobilised and managed according to the commitment imposed by the organization (Nogueira & de Santana 2003:85).

In the public sector, human resources management works closely with the government civil or public services to ensure that policies, regulations and conditions of service are implemented and adhered to (WHO 2005a:73). In view of the aforementioned, it can be concluded that the function of human resources management broadly constitutes all organizational policies and strategies concerning human resources management. These include the following (WHO 2003c:4)

- Formulation of human resources policies within the overall health policy;
- Developing of macro-plans and micro-plans for development of human resources for health;
- Education, training, skills and competency development;
- Human resources management;
- Regulation of health professions; and
- Research.

2.3.1 Planning and Policies

Formulating human resources policy is an expression of commitment to guide health personnel towards achievement of the goal (WHO 2003c:15). Human resources planning, on the other hand is the process of anticipating future staffing needs and human resource-related actions to ensure that a sufficient pool of skilled and motivated people with the right skills mix and experience will be available to meet the organizational needs in the long term (O'Brien-Pallas, Birch, Baumann & Murphy 2003:36). Health services and human

resources policies and plans are key instruments for implementing decisions affecting the type of human resources needed for delivery of health care.

Human resources policy formulation and plan development are important factors in the human resources management process (WHO 1998:4). However, in many cases, there is a mismatch between human resources management policies and their implementation (Bach 2001:107); in many countries these plans are not approved and costed (WHO 2003a:8).

2.3.2 Production and education

Training and producing adequate health workers is a challenge in the African region. Production of the health workforce involves systematic training of staff in preparation for work in the health sector. It involves all aspects related to basic and post-basic education and training of the health labour force and includes all training institutions managed by public, private and nongovernmental organization authorities (WHO 2002:4).

Education of the health workforce is seen as a long-term investment in human capital and should be aimed at meeting the demands of health systems. However, education institutions in Africa are failing to produce adequate health workers (Loewenson & Thompson 2004:24). The situation in Africa is mirrored by shortages of key health workers. In fact the workforce density of 0.8 health worker per 1,000 population is notably very low compared to the world median density of five health workers per 1,000 (High-Level Forum on

Health MDGs 2004:2). It is therefore important for any institution producing human resources to be guided by human resources for health plans and policies (Mercer, Dal Poz, Adams, Stilwell, Buchan, Dreesch, Zurn and Beaglehole 2003:469).

2.3.3 Staff utilisation and retention

Deployment, equitable distribution and utilisation of appropriate staff to match the organization's strategies remain important aspects of human resources management. These aspects are important because they guide the effective distribution, deployment and utilisation of appropriate staff by placing them in the right jobs and retaining them where they are most needed (Price 2000: 26: WHO 2005a:13).

Various factors have been identified as being linked to motivation and retention of staff in their workplace. These factors are discussed in detail below.

2.3.3.1 Working conditions and work environment

According to Bezuidenhout (1994:46), *working conditions* refers to "...the interaction of an employee with the physical work environment". Working conditions include *physical conditions* such as working tools, equipment, materials, and schedules. *Psychological conditions* include work pressure and stress, and *physical layout* refers to a clean and comfortable environment.

Working conditions have been singled out, along with remuneration, as one of the major demotivators and are often the reason why professional nurses leave the profession (Awases et al 2004:54**).** This view was verified by a report by the CHSRF (2001:1, 4) which identified work pressures and safety as some of the issues affecting nursing work environment.

The report stresses that nurses' work demands put extreme pressure on them and do not correlate with their skills and knowledge. At the same time, the continuous understaffing results in overburdening available staff with heavy workloads. Regarding workplace safety, the report shows a relationship between staff shortages, heavy workload, stress and injuries such as musculoskeletal injuries, low-back pain and injuries from sharp objects.

2.3.3.2. Motivation

According to Swansburg and Swansburg (1999:479), "…motivation is a concept used to describe both the extrinsic conditions that stimulate certain behaviour and the intrinsic responses that demonstrates that behaviour in human beings". Motivation is seen as the most crucial worker's attribute for improving performance and includes a mix of complex factors such as personal values, professional ethics, incentives, workspace and environment (Joint Learning Initiative 2004:75).

Two types of theories of motivation have been identified and concern **content** and **process.** Content theories focus on individual needs that strengthen, prolong and lead behaviour. Aspects that motivate nurses may include issues of psychological need for safety, respect and status that may lead to self-respect and self-fulfillment. Other individual cognitive needs include need for knowledge and understanding, feeling of belonging, and issues of job security, fair working conditions and interpersonal relations. Maslow's need-hierarchy and Herzberg's motivation-hygiene theory are some of the theories that relates to the content theory (Swansburg & Swansburg 1999:481; Jooste 1993b:439; Daft & Noe 2001:192).

The process theory of motivation is also called *behaviour modification*. It is based on the notion that learning occurs because of behaviour; it advocates for reinforcement of good behaviour through reward, praise and recognition. Reinforcement motivates and improves the strength of a response, and undesirable behaviour should be modified and not punished (Swansburg & Swansburg 1999:480; Jooste 1993b: 439; Daft & Noe 2001:192).

Sirota (2002:5) identifies three primary goals that motivate people at work: equity, achievement and camaraderie. These also support the content and process theories. He called this the 'Three-Factor theory of human motivation in the workplace' and it includes

- **Equity:** Employees would like to be treated justly in relation to the basic conditions of employment. These basic conditions include *physiologica*l needs, that is, safe working conditions, reasonable

workload and comfort; economic needs of job security, satisfactory remuneration and benefits; and *psychological needs* of respect, good interpersonal relations and credible management**.**

- **Achievement:** Employees want to take pride in their accomplishments by doing a job that matters to them; to receive recognition for their accomplishments and take pride in the organization's achievements.

- **Camaraderie:** Employees wish to have warm, interesting, and cooperative relations with others in the workplace.

2.3.3.3 Remuneration and incentives

Hicks and Adams (2003:258) defines remuneration as "…the total income of an individual and may comprise a range of separate payments determined according to different rules". The WHO (2000:11) defines incentives as "…all rewards and payments that providers face as a consequence of the organizations in which they work, the institutions under which they operate and specific interventions they provide".

Financial incentives consist of pay, other direct financial benefits (such as pensions, health insurance, dependent allowance, clothing/housing allowances) and indirect financial benefits (such as subsidies for transport, meals and child care). Non-financial incentives include flexible working hours, sabbaticals, study leave, planned career breaks, occupational health and

counseling, access to support for training and education (Hicks & Adams 2003:258).

Payment and incentives are seen as having a profound effect on performance. According to the WHO (2003b:12), raising wages in developing countries where workers are paid less than in developed countries will increase productivity; however, it may be less successful in countries where salaries are already high. Nonetheless, increasing wages and other non-financial benefits such as accommodation, transport, on-the-job training and opportunities for promotion and rotation has been shown to increase productivity.

According to the CHSRF (2001:12), there is a relation between nurses' satisfaction with their salaries and their job satisfaction; however, the salary becomes an issue of concern usually in the absence of other factors of satisfaction such as recognition, opportunities for personal development and growth. The current situation in the African region portrays a picture of poor remuneration packages and low wages in quite a number of countries. There exist major differences in salaries between countries. For instance, it was found that a general practitioner in one country is paid US$40 per month compared to US$700 in another country (WHO 2003a:10).

2.3.4 Human resources development models

Price (2000:26) identifies two models that are influential to the *development o*f *human resources management*. The Harvard model emphasises the soft approach and provides a strategic map which guides manager-employee relationships. This approach includes characteristics such as motivating people through their involvement in decision-making, creating an organizational culture based on trust and teamwork, supporting the notion that people can influence the outcome or achievements of an organization. According to Hendry (1995:5), the Harvard model of *human resources management* includes an integrative framework of personnel management. This is indicated in the fact that both forms of management recognise the tense relationship between corporate needs for control and individual needs for personal achievement.

On the other hand, the Michigan model focuses more on the harder resources. This approach advocates that people should be treated like all other resources in an organization: they should be obtained cheaply, used scarcely, developed and exploited. This approach develops human resources policies and strategies that combine the available human resources with the organization's goals. The matching of available human resources to achievements is done through regular restructuring, performance-related pay and downsizing (Price 2000:27).

A paper by Buchan (2004:2) aimed at looking at how *human resources management* has been defined and evaluated in non-health sectors compared to the health sector in the United Kingdom stresses the uniqueness and complexity of human resources management in the health sector which somehow supports the Michigan model. For example, the organizational context is different from other sectors. Performance is mainly assessed with health sector-specific indicators such as clinical activities, workload, measure of outputs, patients treated, or mortality rate. An important aspect in human resources for health systems management is the need to match interventions with context, characteristics and the priorities of the organization (Buchan 2004:4).

According to the CHSRF (2001:1), the challenge of *human resources management* policies is to create a conducive working environment or healthy workplace that will enhance the work of the nursing workforce. A key strategy to enhance the work of staff in an organization is *performance management*. Some of the key policies or strategies are discussed below.

2.4 PERFORMANCE MANAGEMENT

Performance management is one of the most important and critical functions of human resource management. It is seen as a way of establishing mechanisms for reviewing the performance of staff, and helping them to

effectively contribute towards the achievement of organizational objectives (Price 2000:181; Martineau 2005:7).

2.4.1 Definition and clarification of concepts

Authors differ as to the understanding of performance management. Katz and Green (1997:7) define performance management as "…a system composed of an orderly series of programmes designed to define, measure, and improve organizational performance". The PSMPC (2000:1) defines performance management as "…helping people to work more effectively by improving individual and team performance, increasing the overall productivity of an agency" in the context of staff management. The Institute of Personnel Management as quoted by Martinez (2003:206) defines performance management as "…a strategy which relates to every activity of the organization set in the context of its human resources policies, culture, style and communications systems. The nature of strategy depends on the organizational context and can vary from organization to organization".

Performance management is a shared process between managers, the individual and the teams they are supervising; it is designed to improve the performance of an organization and the people working within it (Armstrong 1994:1; Torrington & Hall 1998:317). Performance management is based on agreed objectives, competencies required to undertake the work and development plans for achieving the objectives. Performance management

focuses on strategically increasing the effectiveness of an organization through improving the productivity of its people.

According to Price (2000:181), Armstrong (1994:1), Amaratunga and Baldry (2002:218), Van der Bij and Vissers (1999:214) and De Bruijn (2002:579), performance management systems incorporate performance assessment or appraisal systems which are specifically developed to appraise the performance of individuals or teams. Such appraisal requires the following:

- Clearly defined organizational goals,
- Individual or team objectives or management targets,
- Properly defined standards of performance and the skills and competency required to meet them,
- Regular formal review of progress.
- Systems of feedback and proposals for improvement.

Armstrong (1994:25) says that the aims of performance management and human resources management are similar, namely, to achieve sustained improved performance of organizations and employees to ensure that people develop and achieve their fullest capacity and potential for their own benefit and that of the organization. Furthermore, performance management aims at creating an environment which values people, empowering people in a way that latent potential can be realised, and to strengthen or change positively the organization's culture.

2.4.2 Performance management philosophy

Performance management is underpinned by a philosophy based on a holistic approach and consists of a motivational theory, the concept of organizational effectiveness and beliefs about how performance is managed in the organization.

The three main aspects of motivational theory which drives behaviour are goals, reinforcement and expectancy. **Goals** are set in collaboration with employees and should be challenging but feasible. Feedback should be provided as to whether the goals are achieved. **Reinforcement** urges the achievement of goals set, and the reward for acceptable achievements will act as incentive and so strengthen the good behaviour which employees normally would repeat in a similar situation. **Expectancy** stresses that people will be motivated to change their behaviour in order to enhance performance if they feel that the changed behaviour will be rewarded appropriately (Armstrong 1994:30; Daft & Noe 2001:193).

Contrary to the above, Van Leberghe, Adams and Ferrinho (2003:424) stated that it is naïve to regard performance management systems as a magic solution. There is very modest evidence that formal performance management systems actually have an influence on the quality of care or patients' outcomes and none have shown that the returns in efficiency outweigh the cost of setting up the system. However, there is also no evidence to the contrary.

Organizational effectiveness depends on clarifying strategies, communicating clearly and providing a learning environment. Clear corporate strategies and values are important for success. Objectives will be achieved if they are well-integrated. *Top-down* integration is a process where objectives are cascaded down at each level of the organization. *Upward integration* enables employees to contribute to their own objectives as well as to those of the organization. *Lateral integration* allows various teams to operate interdependently, laterally and crosswise. Effective performance management also provides opportunity for upward and lateral communication (Frontline Management 2005:2).

It is important to understand that performance management is only a means to achieve an end and not a panacea. Performance management is based on an assumption that there is a link between organizational and individual performance (Armstrong 1994:26; Hornby & Forte 2002:3). This assumption is disputable because an organization's contextual factors are not always in place before the performance management system is considered.

However, despite the absence of fully integrated performance management systems, most health systems in developing countries attempt a design that focuses mainly on the enhancement of staff performance through staff or performance appraisal reviews (Martinez 2003:221).

2.4.3 Performance appraisal

Performance or staff appraisal is an approach used for many years in organizations where an individual is assessed by an immediate supervisor. In many developing countries, staff appraisals are not implemented as part of a management process (Martinez 2003:211).

2.4.3.1 Definition and clarification of concepts

According to Troskie (1993:534) and Torrington and Hall (1998:325) performance appraisal is about ascertaining the value of a person's work performance by assessing an employee's strength and developmental needs using different measurements and evaluation methods. The key in performance analysis is the identification of the gap between desired and actual performance. This will provide clarity on the expected performance (goals) and the current situation (baseline) to enable monitoring of progress (Winch et al 2003:10).

2.4.3.2 Purpose of appraisal

Various authors (Troskie 1993:534; Hornby & Forte 2002:1; Price 2000:185; ISPI 2000:3) discuss the main reasons for evaluating or measuring performance. They include the following:

- Improvement of work performance by enhancing the productivity of an employee;

- Identification of excellent performers with the aim of rewarding people who are ready for promotion;
- Identification of those who need some type of support to improve and increase their work performance;
- Determining whether the set targets have been achieved and whether laid down standards have been adhered to;
- Remuneration according to achievement (merit pay);
- Detection and elimination of problem areas in jobs or the work environment;
- Placement of staff according to their ability; and
- Reduction or elimination of grievances.

2.4.3.3 Reasons why performance appraisal fails

According to Torrington and Hall (1998:325) appraisal systems are designed to measure personalities, behaviour or performance through the use of quantitative or qualitative methods. Torrington and Hall also stressed that qualitative appraisal proved to be more difficult to implement because of its subjective nature and therefore important areas are sometimes not appraised.

Many times performance appraisals have failed to do what they are supposed to do. Troskie (1993:534), Torrington and Hall (1998:325), Hornby and Forte (2002:1) and Price (2000:185) stated the following reasons for failed appraisal systems:

- Incomplete data gathering and using limited criteria can create a false image;
- Effective appraisal takes time and energy, it should be a continuous process, and it cannot be left until the last minute (as is the case in some organizations);
- One important problem is subjectivity in the appraiser's judgement;
- The halo effect happens when judgement is based on a general impression and the appraiser then evaluates all elements at the same level;
- Tendency for appraisers to settle on the mid-point of the rating scale due to either lack of knowledge of the appraisee or trying not to be too firm on the appraisee;
- Measurement standards should be clear and understood by both the employer and employee so that they are aware of what is expected from them;
- Ego-involvement is when a supervisor's ego causes an employee to be evaluated higher than is deserved.

2.4.3.4 Performance measurement

Measurement and evaluation are used to strengthen and improve performance practices. According to WCPS (2001:47), measures "…are the yardsticks used to determine how well work units and employees produced or provided products or services". It is crucial that the intended outcome of an intervention to be measured and assessed is clearly described and known;

secondly, that appropriate methods are used and; thirdly to determine whether the selected activities and interventions will narrow or close the performance gap. Performance measurement also validates acceptable performance as well as evaluates any changes or variation in delivery of care. Furthermore, evaluation of variance allows for identification of opportunities to improve service delivery (Sutherland, Makin, Bright & Cox 1995:12; Katz & Green 1997:27).

The importance of measurement in the performance improvement process cannot be overemphasised. As Sutherland et al (1995:12) mention, “...If you cannot understand something you cannot measure it. If you cannot measure it you cannot control it. If you cannot control it you cannot improve it”.

However, Halachmi (2002:231) argues that performance measures have some serious dysfunctions that need to be looked at during the review of existing performance appraisal systems or when new ones are considered. For a performance appraisal review programme to be successful, the organization must commit the necessary financial and human resources for achieving the desired outcomes, ensure that the objectives to be assessed are known by all concerned, and agree on the timeframe or period for assessment (Halachmi 2002:232).

- *Standards*

Katz and Green (1997:9) define a standard as a "...written value statement of rules, conditions, and actions in a patient, staff member, or the system that is sanctioned by an appropriate authority". WCPS (2001:52) define standards as "…management-approved expressions of performance threshold(s), requirement(s), or expression(s) that employees must meet to be appraised at particular levels of performance".

According to Muller (1993:600), a standard is "…a valid explicit description of the desired quality of job performance and contains **criteria** or **indicators** for assessing the quality of nursing tasks". Performance standards are written statements describing the level of performance expected for satisfactory achievement (Armstrong 1994:58; Katz & Green 1997:91).

According to Necochea and Fort (2003:13), standards should be based on a solid foundation of evidence and should be developed with input from different relevant stakeholders, management cadres and health providers themselves. However, it was observed that developing countries are constrained by lack of standards for practices, or outdated norms and standards; there is seldom institutional capacity to provide evidence-based information to guide the development of performance standards (Necochea & Fort 2003:9).

With regard to nursing, clinical standards or performance standards are descriptions of the desired level of performance and are developed as a basis

of evaluating the quality of nursing care (Swansburg & Swansburg 1999:712; Unisa 1995:17). The main advantages of nursing care standards are that they demarcate the scope and content of quality care and provide a benchmark for assessing the quality of care (Unisa 1995:17).

Performance standards should be measurable and known to both the supervisor and employee. Three types of standards are identified:

- **Structural standards** deal with the physical, organizational structure and legal parameters in which staff operate and include the mission, philosophy, goals, policies, job description, equipment, supplies and numbers of personnel needed to perform the task.

- **Process standards** deal with the **how** or the process of delivering the actual health-care delivery interventions and consist of dimensions such as nursing process tools (assessment, planning, implementation and evaluation) which are used to determine service delivery and take many formats such as procedural guidelines, performance indicators and documentation. Process standards are written standards that transform the organization's values into interventions and actions.

- **Product** or **outcome** standards refer to expected or desired outcomes of interventions or results that have to be achieved such as the change in patient health status after nursing care intervention. Product standards

should have a quantifiable value (Muller 1993:601; Armstrong 1994:65; Katz & Green 1997:91).

According to Carlyle and Ellison (1987:77), the criteria for developing standards should be identified well before embarking upon this exercise. Three criteria for identifying standards are distinguished. *Quantitative* criteria concern quantity (numbers, how much and how many) of the product or outcome to be achieved. *Timeliness* is concerned with the duration of time necessary for achieving a task, how quickly and at what date a product is to be delivered. *Qualitative* criteria are the most difficult to measure. They include broader concepts and involve some degree of subjective judgement and thus are open to interpretation. They are also concerned with effectiveness and degree of efficiency of the final product, i.e. how well and how good.

According to Rafferty et al (2005:16), until the 1990s the quality improvement efforts were directed towards structural and process standards. However, there are gradual changes to emphasise patient and outcome standards.

- *Clinical criteria*

Nursing care criteria or *objectives* are derived from approved nursing standards to serve as a practical measuring scale for assessing quality of care. The fundamentals of nursing criteria are that they should be *achievable* by reasonable action, *specific* by describing exact action, *concise* by conveying a clear message, and understandable by signifying only one clear, unambiguous message (Unisa 1995:18).

- *Performance indicators*

A performance indicator is a specific type of measurement that is intended to measure desired performance outcomes based on reliable, quantitative processes or outcome measures related to one or more dimensions of performance such as efficiency, effectiveness, efficacy, appropriateness, timeliness, availability, continuity, safety, respect and caring (Katz & Green 1997:106).

Indicators related to patient care are called **clinical indicators**. According to Katz and Green (1997:106), a clinical indicator is a "…quantitative measure that can be used to measure and evaluate the quality of important patient care and support services. It is not a direct measure of quality but rather a flag that points to specific issues that require more intensive review" (Katz & Green 1997:106).

The World Health Report 2000: *Health systems: Improving performance* (WHO 2000:24) stressed the importance of health systems being more outcomes-oriented. It also highlighted that performance of health systems depends on the knowledge, skills and motivation of the people responsible for delivering services (WHO 2003b:7). Performance indicators are tools that monitor and enhance the performance of an organization in general, including the clinical level (Hornby & Forte 2002:1); they quantitatively measure whether an initiative has achieved its stated goals (WHO 2005a:13).

The human resources performance indicators concern the development and utilisation of staff in an organization and are designed to monitor the levels of

organizational and individual staff performance. According to Hornby and Forte (2002:2) and Troskie (1993:534), performance indicators are helpful for:

- Developing an organization that learns through assessing and managing its performance;
- Achieving outcome-based and business-based management;
- Introducing management processes which support fundamental values of the organization such as quality of service rendered, patient and client access, and the process of restructuring (e.g. health sector reform);
- Linking achievements to available resources and operational processes;
- Mobilising the workforce to enhance individual performance through the performance management process.

Measuring performance means setting organizational goals to be implemented by managers and their health teams; it also means developing a set of realistic targets to measure progress. It is assumed that measuring performance and developing performance indicators for health facilities will automatically lead to performance improvement (WHO 2005c:5). However this is not always the case. The reality is more complex. There is evidence that performance indicators that promote judgement may provide perverse incentives and could prove counter-productive in some cases (Mullen 2004:217). Indicators that promote learning, investigation, professional values, and trust have positive effects on performance. Approaches that involve judgement, tables of ratings, imposed performance improvement and lack of trust have negative effects on performance (Mullen 2004:226).

It is important to ensure that performance standards are described carefully and precisely to ensure that they contain all the key components of what is being assessed (output) and the criteria upon which assessment is based, i.e. quality, quantity and timeliness. In some cases, Rafferty et al (2005:17), Armstrong (1994:56), and Carlyle and Ellison (1987:78) all agreed that description of standards should be stated as SMART:

S – Stated concretely and specifically,

M - Meaningful and practically measurable,

A - Agreed upon between manager and employee,

R – Realistic, achievable and based on sound rationale, should be within the role and scope of the employee,

T – Time related and thus achievable in a defined time period.

- *Measurement tools*

Various instruments for measuring individual and team performance are available. There are often subtle distinctions between these tools (Hofer, Bernstein, Hayward, DeMonner 1999:456). However, there are numerous constraints that limit the usefulness of tools (Rafferty et al 2005:39); for instance, what often gets measured are the simple aspects, and occasionally what is measured is not meaningful (Price 2000:193).

Traditional approaches were based on a top-down approach whereby the supervisor or manager informed the employee about the outcome of the

appraisal. The supervisor did all the talking with little response or input from the subordinate. However, new methods for performance appraisal suggest appraisal to be a two-way dialogue between a manager and the subordinate that provides them with an opportunity to assess and discuss the factors affecting performance and jointly agreeing on the actions to be taken (Armstrong 1994:119).

Various performance appraisal methods have been used. One is the traditional annual individual performance appraisals. Although various critics oppose this method, it remains one of the most used methods. Another method, self-assessment, is when individuals review their own performance as part of individual performance appraisal. A 360-degree feedback survey is the most recent approach where data are acquired through research and surveys, mainly voluntarily. Other methods include probationary reviews, counselling meetings, one-to-one review discussions relating to performance outcomes, supervision and direct observation on-the-job (Price 2000:193; Chapman 1995:2; Troskie 1993:539; Necochea & Fort 2003:10; Rafferty et al 2005:30).

Peer assessment is when team members and colleagues who are in the same unit or level rate each other on identified aspects. Likewise, team performance review meetings assess productivity output and quality standards. The team agrees on steps to be taken to avoid non-productive occurrences in future.

Upward assessment is part of the normal review procedure and provides opportunity for a subordinate to comment on a specific aspect of supervisor or manager performance. This ensures that managers are getting feedback on their

own ability from the point of view of their subordinates. To ensure effective implementation of upward feedback, a mediator or facilitator may be required to complete the process. An open appraisal system is a useful mechanism for reviewing performance, helping staff to improve specific aspects of their work (Chapman 1995:2; Troskie 1993:539; Armstrong 1994:119).

Rafferty et al (2005:39) highlight reviews of different instruments developed for different health care settings and situations. The importance of balancing various factors when choosing an instrument was stressed. Issues such as target staff, the ultimate use of the instrument, the method and the conceptual theory of the instrument should be considered.

2.4.3.5 Performance appraisal feedback

According to Armstrong (1994:127), "…feedback transmits information on performance from one part of a system to an earlier part of the system in order to generate corrective actions or to initiate new action". This implies that performance management provides an opportunity for feedback to be presented to employees concerning their performance. This is aimed at helping them to understand the level of their performance (how well they are doing and how effective their behaviour has been) and to take corrective measures if performance was below expectation or to reinforce and strengthen positive or good performance. The importance of feedback on both success and failure has been highlighted for reinforcement of behaviour (Rafferty et al 2005:30; Troskie

1993:536; Armstrong 1994:119; Rowe, de Savigny, Lanata & Victora 2005:1; Adams 2005:24).

Effective and timely feedback is essential. Feedback works well when it relates to a specific standard or indicator. It should be given as soon as the behaviour has taken place and should be provided in a way that will contribute to improvement of performance (WCPS 2001:62).

The nature of feedback varies according to the situation and may take the form of an interview between the supervisor and subordinate after the subordinate has read the appraisal report (Booyens 1993a:422; Price 2000:206). Other forms of feedback are done through written communications and incident reports or through oral communication such as counselling, interviewing and coaching (Jooste 1993a:269; Armstrong 1994:129). However, too often supervisors lack the skills for effectively communicating the performance appraisal outcomes (Rowe et al 2005:3). In some cases, the performance appraisal outcome is kept confidential and not communicated to the subordinate (Martinez 2003:210).

According to Jooste (1993a:269), sufficient and immediate feedback should be given on a continuous basis to ensure immediate response and improvement in performance. This should be done in intervals of four to six months and should not be left to the end of a year. Price (2000:209) mentioned that supervisors should take their views from a wide range of perspectives, including from other colleagues to help in providing a better assessment report.

2.4.4 Performance Improvement

Katz and Green (1997:28) and WCPS (2001:25) stress the importance of having a performance improvement programme as part of performance management. The performance improvement plan should address the question of **how** to improve the level of performance.

2.4.4.1 Clarification of concepts

Performance improvement is a response to make services of an organization better, affordable and faster. It seeks to rectify any problems that exist and build upon those performance levels that are already good (Katz & Green 1997:28).

According to Katz and Green (1997:200), performance improvement involves the "...resolution of performance problems and the exploitation of performance opportunities". Problems may be related to service, practice or governance. Performance opportunities "...consist of those occasions when, although the performance target is adequate, an opportunity exists to improve the outcome of the service or the process by which the services is delivered" (Katz & Green 1997:200).

Winch et al (2003:5-11) propose a performance improvement process for health workers administering home-based care. They describe clear steps to be followed by health managers to ensure that interventions selected to improve health worker performance are consistent with the identified gap in performance.

The factors identified are similar to those in the performance model, and the steps in the performance improvement process are the following:

- *Stakeholder agreement:* everyone involved agrees on the intended interventions; this includes the necessary staff mix;

- *Organizational context*: assessment of various factors includes goals, strategies of health care delivery systems and other organizational factors such as culture, client and community perspectives;

- *Performance analysis and design of desired performance:* the gap between desired and actual performance is defined; guidelines explain how to achieve the desired performance as well as develop standards, job descriptions and competencies required to perform optimally;

- *Conducting performance analysis and assessment:* procedures include direct observation, interviews, assessment of records, surveys, focus group discussion and feedback;

- *Find root causes of the gap in performance:* most relevant and effective actions to be taken should be identified through root cause analysis;

- *Selection of best solutions and interventions for the gap:* one factor or gap may require several solutions.

2.4.4.2 Monitoring for performance enhancement

According to Swansburg and Swansburg (1999:694), monitoring is one of the most important tools in managing productivity of nurses. Performance monitoring and appraisal outcomes can be used to manage and enhance performance and productivity through training, counselling and development. According to the WCPS (2001:61), monitoring performance implies assessing the performance and providing feedback on an employee's performance level with the aim of jointly agreeing on how to address the aspects employees are struggling with as well as to reinforce the areas that are performed well.

Since most functions of organizations are oriented around performance, performance monitoring is therefore a management task that attempts to ensure that productivity and staff performance are kept up to standard through formal or informal staff development activities. Some of these activities are discussed below.

- *Staff development*

Staff development is defined as a "…management programme to aid staff in developing skills and knowledge which add to their professional goals and at the same time increase their values as employees" (Swansburg & Swansburg 1999:570). According to Price (2000:349), current organizational practice with regard to staff development is confined to 'training in its narrower sense' instead of a much broader human resources development programme.

Development programmes in an organization should focus on much wider aspects than training (Price 2000:348; Booyens 1993b:375).

- *Induction*

Induction training is introducing new staff to their new working environment and the operation of the organization to assist them to settle in quicker and become acquainted with their work. It helps to reduce anxiety and stress from the uncertainty of working in a new environment. Induction is usually conducted by the personnel division and covers aspects such as organizational structure, conditions of work, policies and procedures, philosophy and mission of the organization (Booyens 1993b:367).

- *Orientation*

Orientation refers "…to personalised training of the individual employee so that he/she becomes acquainted with requirements of the job itself". In the health-care sector, it is conducted in the clinical ward. Orientation covers aspects of the clinical ward or unit to which the new employee is assigned such as standards and norms for patient care (Booyens 1993b:367).

- *Coaching*

*"...*Coaching is a personal (usually one-to-one) on-the-job approach to helping people develop their skills" (Armstrong 1994:131). Coaching is embedded in the day-to-day activities whereby a supervisor provides support to the subordinates concerning tasks delegated to them. Coaching may also arise

from informal and formal performance reviews and may be directed towards improving a specific task or competency (Armstrong 1994:132).

- Counselling

Counselling is an activity in the workplace where an experienced individual, usually someone in a supervisory position, assists another individual to take more personal responsibility for managing work, making decisions on important matters and ensuring self-development. The counselling process includes three stages:

- recognition and agreement that there is a performance gap or problem;
- empowering by enabling employees to recognise and identify their shortcomings;
- resourcing or managing the problem and agreeing about the right person to act as the counsellor to address the problem.

- *In-service training*

In-service training is about facilitating learning and development of an employee while rendering a service to an organization (Booyens 1993b:367). According to Swansburg and Swansburg (1999:571), "…In-service education provides learning experience in the work settings for the purpose of refining new skills". In an organization, managers and supervisors are responsible for developing employees' potential and abilities to perform, and helping them adjust to rapidly changing job requirements. Supervisors, therefore, should continuously assess gaps and the potential abilities of their subordinates in

order to provide planned in-service training to correct matters (Booyens 1993b:369; Price 2000:366).

According to Booyens (1993b:370) and Price (2000:365), training needs can be analysed. One way is to assess the organization as a whole, how it does its business. The analysis should provide benchmarks against which the effectiveness of training programmes can be evaluated. Medium-term and long-term strategies will be assessed. A second way is to consider the organization's financial commitment to support an in-service training programme. Thirdly, it is necessary to determine exactly where training is needed. Information on needs could be provided by internal audits, performance appraisal, skills inventory and patients.

There are various forms and methods of in-service training. The following list contains informal and formal development methods for employees in terms of in-service training:

- *On-the-job training*. An employee is taught in the clinical unit or ward through observing tasks, simulation and by performing tasks under supervision.
- *Mentoring and coaching.* Subordinates are supervised by experienced managers or mentors who provide support and advice and thus build the confidence of junior employees.
- *Job rotation.* Junior employees rotate between various clinical units for broader learning experience.

- *Planned formal in-service educational programmes.* Programmes are organised by a designated department and are mostly attended by groups.
- *Computer-based self management training.* Computer-based training is the newest technology and has reduced reliance on traditional mechanisms of in-service training. Computer-based programmes are becoming a popular mode of training in organizations.
- *Distance learning.* This rapidly expanding field of learning offers short self-contained courses or long-term degree and research opportunities (Booyens 1993b:373; Price 2000:365).

- *Continuous education*

Continuous education programmes in organizations are aimed at updating employees' knowledge and competency in order to increase their capacity to analyse complex health problems, deliver and maintain health services, and sustain professional interpersonal relationships (Booyens 1993b:374; Swansburg & Swansburg 1999:571).

According to Booyens (1993b:375) and Swansburg and Swansburg (1999:571), continuous education is usually part of the self-development responsibility of the employee; however, organizations may need to accept this responsibility to ensure that their staff are kept up-to-date with new developments. This may take the form of workshops, conferences, seminars, self-learning modules, individual studies or degree courses.

- *Supervision*

Supervision deals with evaluating the effectiveness of performance of employees within an organization, both horizontally and vertically. Supervision includes aspects such as planning, measuring, problem-solving, communication, guiding, leading, instruction, advising and encouraging of work done by subordinates (Jooste 1996a:284). Supervision takes place at various levels of an organization and is conducted by managers or specifically appointed supervisors or stewards (Jooste 1996a: 285; Price 2000:209).

In professional health-care settings, the focus of supervision depends on the discipline of the unit or institution. For example, there is clinical, educational and managerial supervision with the ultimate goal of ensuring that employees will provide safe patient care; such supervision also promotes professional development of practitioners (Hesketh & Laidlaw 2003:2).

In nursing, supervision occurs at all levels of the hierarchy of nursing service delivery, i.e. from the level of management of nursing services to the first level of the clinical setting (Jooste 1996a:286). Clinical supervision is a management tool that provides support, guidance and assistance to all members of the health team working within a specific ward or unit. These include professional and sub-professional nurses, technicians, domestic workers, students and administrative support staff (Jooste 1996a:287). Supervisors in clinical settings impart knowledge and competence through demonstration of procedures, explanation and asking questions while

rendering care. They also observe staff work and recognise deficiencies that need to be corrected (Hesketh & Laidlaw 2003:2).

Supervision consists of three key elements: **development, monitoring and support.** *Development* of staff can be achieved by facilitating opportunities for further development, orientating new workers to settle faster into the organization, on the job training, sharing knowledge, and constructive feedback which directs staff towards achievement of set goals. *Monitoring* includes identification of poor performance and suggesting ways for improvement, early recognition and changing of potential problems such as deviation from the set standards and norms and detection of burn-out before it can become a real problem. *Support* ensures effective communication by maintaining open communication lines. It confronts anxiety and stress by exploring how stress should be avoided in the future.

Supportive supervisors challenge workers to accept new responsibilities; they delegate responsibilities regularly, maintaining balance between supervising and allowing certain amounts of autonomy (Jooste 1996a:287-293, Hesketh & Laidlaw 2003:9). Contrary to the above, health services in developing countries are hampered by lack of skilled supervisors, lack of supervisory tools, heavy administrative work that keeps supervisors in offices rather than with health workers. There is little support for the supervisor, and no one cares if supervision is done or not (Rowe et al 2005:4).

2.4.4.3 Performance improvement development plan

Developing and enhancing the performance of staff is an important function of an organization. According to Katz and Green (1997:201), it is imperative to have a proactive performance improvement plan which is crucial to address critical issues identified which may be related to service, practice and governance. The process of planning for improvement should be done continuously in a systematic way through "… selecting risk-taking decisions today with the greatest knowledge of their effects on the future; organising efforts necessary to carry out these decisions; and evaluating results of those decisions against expected outcomes through reliable feedback mechanisms" (Katz & Green 1997:201).

There are three types of plans: clinical plans, professional practice plans and administrative action plans. *Clinical plans* are developed when the issue that needs change deals with service. In that case, the plan is usually directed to the customer or patient. Patient-oriented plans are clinical in nature. When the matter to be addressed concerns the health worker, then the improvement plan is directed towards the practitioner: a *professional practice plan*. Finally, a*dministrative action plans* deal with governance and are developed when problems or opportunities related to systems occur or exist (Katz & Green 1997:201; WCPS 2001:20).

A prerequisite for implementing successful performance *management* systems depends on effective organizational management systems to handle

all aspects such as information, staff, financial control and communication between various levels. The public sector in developing countries endures many limitations in the management of its institutions.

2.5 MANAGEMENT

Management is a process whereby work is done through people. The manager's functions include many interrelated tasks such as planning, organising, directing and control (Koch 1996:98).

2.5.1 Definition

According to Davidson (2003:689) "...management is the act of managing something". Robbins and Coulter (2002:5) describe management as "...a process of coordinating work activities so that they are completed efficiently and effectively with and through people". The concept of management by objectives refers to a management style that integrates various key managerial activities that aim at improving the effectiveness of an organization.

Daft and Noe (2001:17) emphasise that managers have the responsibility to achieve organizational goals by facilitating, directing and enabling the activities of others in order to maintain the goals of the organization.

2.5.2 Functions and skills of managers

Functions of any manager in an organization are similar and include the basic functions of planning, organising, leading and controlling. **Planning** involves defining of goals, establishing strategies for achieving the goals, and establishing plans to integrate and coordinate the implementation of functions. **Organising** determines what should be done, assigning tasks within the organization, delegating responsibilities and allocating human and financial resources. **Leading** involves guiding, inspiring and motivating all employees to work together towards achieving organizational goals. This function requires good interpersonal and leadership skills. **Controlling** involves monitoring, measuring of performance levels and comparing them to the objectives, reviewing and adapting plans and strategies accordingly (Daft & Noe 2001:20).

Managers require certain **skills** to successfully manage an organization, and to enable them to facilitate and direct activities at all levels. This view is verified by Homer (2001:61) who writes "…management of available skills is an evolving process that is becoming very popular in organizations and is part of human resources management". It is a process of assessing available competencies, determining the skills gap and arranging meaningful training and development intervention.

Three basic skills required by managers as identified by Daft and Noe (2001:18) and Robbins and Coulter (2002:12) are conceptual, human and

technical skills. *Conceptual skills* involve the ability of thinking and planning. The manager should be able to observe the organization as a whole. These skills revolve around decision-making choices by the manager. This skill is needed at the *top management level*. *Human skills* involve the ability to work with and through people. This requires good interpersonal skills to influence productivity through positive human relationships. Examples of human skills include aspects of leading, motivating, communicating and resolving conflict.

These skills are required at all levels but more so at *middle management level***.** *Technical skills* involve understanding and proficiency in carrying out tasks. Managers who have mastered technical skills are needed to guide and oversee the implementation of specific tasks, especially at *lower management* or *operational level*.

Effective management at the national level is one of the most important inputs for a well-functioning health system. The current situation in Africa is that medical doctors and nurses are employed as managers of health services and health facilities without proper preparation for this function. (WHO 2005b:12).

Nursing is a caring profession, and thus the main impetus of nursing management is the focus on human behaviour. Nurse managers should therefore acquire knowledge and skills of human behaviour and be able to effectively manage both professional nurses and other employees. It is therefore important for nurse managers to study nursing theories (such as

Orem's theory) that are generally approved by the profession as part of management style and philosophy as a basis for practice (Swansburg & Swansburg 1999:34).

2.5.3 Management competencies

The notion of management competencies revolves around the need to develop competencies of employers, to continuously assess and evaluate competencies, to determine skills gaps and to regularly maintain personnel skills.

2.5.3.1 Definition

According to Hoffmann (1999:275), the term *competency* has no single definition; instead, it is a multifaceted concept of competencies which derives its definition from the rationale for which its use has been shaped. Competencies therefore may be defined as "... behaviours that an individual needs to demonstrate" or "…minimum standards of performance" (Hoffmann 1999:275).

Three main principles guide the definition of competency. *Observable performance* focuses on a learning process or task to be completed to determine whether a person is competent. The rationale here is to improve or change performance. Competency is seen as a *standard* of acceptable

performance or *quality outcome* of higher levels of acceptable performance. The rationale is to standardise skills, raise standards, introduce change or raise minimum standards. A third principle includes the *underlying attributes of a person* such as knowledge, skills or attitudes required or available. The rationale is to determine the content of learning that will produce competent performance (Hofmann 1999:276; Filerman 2003:4).

Sargent (1987:87) emphasises the competency-based management model as providing unique possibilities for development of organizations' management capabilities by identifying the deficient competencies that are required at each level of the organization, including line managers and supervisors. In the organizational context, competent leaders and managers are considered necessary for the success of the organization. Managers use a set of ongoing decisions and work activities which they take on with employees as they plan, organise, lead and control (Robbins & Coulter 2002:10).

2.5.3.2 Management style and approach

Bititci, Mendibil, Nudurupati, Turner and Garengo (2004:39) report on five case studies which explore the dynamics and relationships between performance measurement, organizational culture and management style. Four of the cases show that all the organizations that had successfully implemented a performance measurement system also had an executive senior manager in place who used an authoritative management style.

The case studies suggested that an authoritative management style is essential for successful implementation of performance measurement systems, but this management style will not sustain the long-term use of the performance management system once an achievement culture is established. Two of the case studies show that although an authoritative management style was used, the successfully implemented performance measurement system will eventually lead to a more participative and consultative management style (Bititci et al 2004:39).

A study by Gapp (2002:338) on the "...system of profound knowledge" approach provides a framework for successful organization transformation. He identifies transformation of current managerial leadership as crucial for optimisation. As a shift from traditional management styles, the profound knowledge approach promotes a change in the development and training of managers. Instead of teaching them to perpetuate a management style based on short-term thinking, they could be taught the concept of profound knowledge which is based on long-term quality principles. This seeks to:

- Promote intrinsic motivation of employees through pride and satisfaction in work;
- Focus on system processes with an emphasis on improvement and innovation based on available statistical information and analytical thinking in decision-making;
- Focus on client-provider relationships rather than hierarchical organization structure;

- Optimise the system of interdependence between programme components to ensure success;
- Provide informal and formal feedback and coaching;
- Base decisions on operational definitions and evidence; and
- Avoid separation of the concepts of management and leadership in organizational practice (Gapp 2002:339-340).

2.5.3.3 Communication

Effective communication forms the basis of any organization's management system. Communication skills therefore become valuable and necessary for nurse managers. According to Swansburg and Swansburg (1999:505), communications involve interpersonal relationships. Jooste (1993a:270) confirms the importance of communication in an organization by stressing that more than 80% of top level managers' time is spent on various forms of communication. The ability for an organization to ensure effective communication between management and employees thus become crucial, and communication skills are therefore some of the most valuable skills of a manager. According to Swansburg and Swansburg (1999:46) the main thrust of nursing management is its focus on human behaviour.

Communication is seen as a strategic instrument to convey clear messages within the organization (Frontline Management 2005:1); therefore, developing a complete understanding and ability to apply management communication

should increase an organization's capacity to respond to change while at the same time strengthening and harnessing staff commitment.

Various channels of flow of communication are used in organizations namely downward, upward and horizontal. *Downward communication* involves the flow of information from higher to lower levels. It is the most used communication channel to the detriment of the other channels (Frontline Management 2005:1-2; Jooste 1993a: 265-267).

Upward communication involves the flow of information from subordinates to supervisor. Though one of the important communication methods, it is seldom utilised in organizations. If used regularly, it strengthens management for decision-making and thus strengthens employee-manager relations in the organization. In some cases, employees fear communicating spontaneously with their supervisors (Frontline Management 2005:2-3; Swansburg & Swansburg 1999:276).

Horizontal communication involves the sharing of information between peers within the same level of authority. It strengthens the common or shared purpose of the group, develops interpersonal support and maintains common efforts with regard to planning of activities and solving problems (Frontline Management 2005:4).

2.5.3.4 Outcome

As mentioned above, management is a process that oversees the implementation of activities by people in an organization to achieve the organizational goals. According to Katz and Green (1997:299), having an effective management system managed by skilled and experience managers will ensure:

- High efficiency, which means low wastage of resources;
- High effectiveness, which means high goal attainment;
- Efficient systems, structures, processes and resources that positively impact on the organization; and
- Managing interpersonal relationships to ensure effective communication processes.

The challenge for nurse managers is to acquire the skills from the most effective management theories and adopt a management style that will create an enabling environment for effective utilisation of the available nursing skills (Swansburg & Swansburg 1999:31). This is a difficult task as the nurse manager is confronted with an ever-changing environment and a mixed group of subordinates that may include non-nursing cadres with varying needs, levels of knowledge and skills, and attitudes.

It is recognised that leadership skills are crucial for a manager to effectively persuade staff to commit themselves to the objectives of the organization. The leadership process will be discussed in the next section.

2.6 LEADERSHIP

There is an increased awareness of the importance of managers in the health sector to have sound leadership skills. Leadership programmes are implemented to empower managers for their leadership role.

2.6.1 Definition and concept clarification

Leadership "...refers to overall patterns of behaviour a leader uses in a specific situation to perform certain tasks and the amount of control or freedom allowed to employees" (Jooste 1996b:167).

Leadership is a process of directing the behaviour of a group of people. It is viewed as a dynamic and interactive process in which three elements are involved; leader, followers and situation (Booyens 1993a:402; Daft & Noe 2001:397). According to Jooste (1996b:158), "…leadership is an internal process which involves leaders influencing group activities and acting as a role-model to inspire people to achieve their personal goals". The success of a leader depends on abilities in authority, position, power, influence, personal success and respect.

Research on theories of leadership failed to come up with a particular set of traits for an effective leader. However, some common traits of good leadership have been identified. The trait theory suggests that leadership stems from various intellectual, personality and ability traits that include

judgement, knowledge and fluency in speech. Behavioural theories suggests that it is the behaviour of the leader rather than personal attributes that determine effectiveness.

A vision is one important factor which the leader uses to energise followers. Vision is a "...picture of a future state of affairs that is attainable, realistic, credible and infinitely better than what exists at the moment". A good and effective leader will provide followers with an attractive future and create an environment where commitment to the common purpose or goals is the rule and not the exception (Booyens 1993a:422).

Leaders need power in order to persuade people to pursue the goals of the organization. "...Power is the ability and willingness to influence behaviour" (Booyens 1993a:429). Jooste (1996b:158) stresses that the position of managerial leaders is rooted within legitimate power, position and authority to lead.

Leaders' main sources of power and influence are:

- Reward power: The ability of a leader to reward behaviour creates a powerful position;
- Coercive power: Ability of a leader to enforce penalties for non-adherence to expected objectives;
- Legitimate power: Originates from an individual's position, such as director of a programme.

- Expert power: A leader has credibility because of expertise such as knowledge, skills and ability (Booyens 1993a: 429; Jooste 1996b: 158).

2.6.2 Leadership styles

Various leadership styles are identified as autocratic, bureaucratic, democratic or participative, and *laissez-faire*. All of these styles have advantages and disadvantages, depending on the situation, type of organization or business and the leader's personality. Leadership can be articulated using more than one style depending on the situation (Booyens 1993a: 408, Daft & Noe 2001:389).

2.6.2.1 Autocratic or authoritative leadership style

In an autocratic leadership style, the leader shows consistent behaviour patterns of acting alone and making unilateral decisions. The leader tends to centralise authority and prefers a formal position, using rewards and coercion to influence followers. The focus is centred on products and tasks rather than human needs. Employees are demotivated and have no feeling of belonging; they show little interest in their work (Jooste 1996b:170; Daft & Noe 2001:385; Swansburg & Swansburg 1999:276). According to Cilliers (1986) as quoted by Bezuidenhout (1994:44), the management style for nurses has been traditionally perceived as autocratic.

2.6.2.2 Bureaucratic leadership style

A bureaucratic style emphasises fixed, rigid rules, procedures, standards and norms. All activities take place in this policy-regulated environment. The leader relates impersonally to employees and this makes them frustrated and powerless (Jooste 1996b:170).

2.6.2.3 Democratic or participative leadership style

A democratic leadership style encourages human relations, teamwork (Swansburg & Swansburg 1999:408) and participation of employees in decision-making. The manager delegates and shares management with employees but provides guidance and support. This is one of the most preferred leadership styles where employees have a degree of freedom to express their views (Jooste 1996b:171; Booyens 1993a:408).

2.6.2.4 Laissez-faire or permissive style

In a *laissez-faire* style, the leader hands over control to the team and serves mainly as a resource person with passive involvement. Employees are given utmost decision-making power, with limited participation from the leader. In the long term, employees may get frustrated with low production and job satisfaction (Jooste 1996b:171; Swansburg & Swansburg 1999:464).

In trying to identified which style is appropriate for nursing managers to pursue, Jooste (1996b:16) is of the opinion that no single style will be

appropriate for all nursing situations. Instead, nurse leaders should adopt the style that suits a specific circumstance.

2.6.2.5 Outcome

A good leader will lead and empower employees to lead themselves. This is called self-management leadership. Good leaders create an environment where their followers are inspired to do well and exceed their performance and are thus offered an attractive future. Staff are committed to the common purpose or goals of the organization (Booyens 1993a:422).

This view is supported by Daft and Noe (2001:400) who emphasise that leaders act as role models and mentors for their staff. Behaviour displayed by leaders will affect, in some way or other, the followers in regard to commitment and confidence to achieve work outcomes; inspiration to set and strive for higher goals; intrinsic reward; increased efforts, improved satisfaction and performance.

Zurn et al (2004:5) stress that, "...Leadership is positively correlated with nurses" job satisfaction and commitment towards institutional goals. The challenge for leaders is to be able to build a sustained long-term vision, to build teams and increase commitment to effect organizational change. Traditionally, the leadership style of nurses has been seen to be autocratic; however, Jooste (1996b:176-177) suggests that this is gradually changing. Future nurse leaders will strive to work alongside subordinates and regard

them as colleagues; they will empower subordinates to become their own leaders and encourage a participatory process in decision-making.

The differences between management and leadership will be discussed in the next section.

2.7 DIFFERENCES BETWEEN MANAGEMENT AND LEADERSHIP

Management and leadership roles are interdependent and sometimes used interchangeably. According to Hollinshead and Leat (1995:22), management refers to the effective utilisation of all resources in an organization and relies more on planning, organizational and communication skills. Leadership also relies on management skills, but it depends more on behavioural qualities such as determination, integrity, humility, courage, honesty, confidence, compassion and positivity. Leadership is therefore an emotional relationship directed to influence people. While leadership is easy to explain, it is not easy to perform (Booyens 1993a:403).

According to Jooste (1996b:159), management and leadership are not synonymous; however, a manager, by virtue of the legitimate power position, may have leadership attributes. Leadership is a learnt behaviour and some managers have the potential of becoming a leader.

The roles of leaders and managers are separate but show some similarity and overlap; they include the roles of decision-maker, client-advocate, educator, role model, motivator, innovator and counsellor.

Table 2.1: Examples of differences between management and leadership

CONCEPT	MANAGEMENT	LEADERSHIP
Interactional process	■ Managers tend to rely on organizational systems rather than on their relationships with people to get tasks done	■ An interpersonal relationship/process which is directly concerned with the interaction between leader and followers
Goal attainment through different styles and behaviour	■ Managers focus on the attainment of specific short-term institutional objectives and aims ■ Managers react to everyday pressures and events ■ Managers focus on the implementation of plans ■ Managers have a less personal attitude towards organizational goals and view goals as reactions or responses to change or forces outside the organization	■ Specific behaviour and strategies are employed to direct and influence individuals to attain the common goal of the organization ■ The leader's influence is directed at the achievement of work performance in specific situations and is aimed at obtaining institutional objectives ■ Leaders are concerned with long-term planning ■ They develop goals for change and a vision for the future
Coordination of tasks	■ Scheduling, coordination and supervision of resources and personnel take place ■ Control is used as a power strategy ■ The manager has access to resources specified by the budget	■ Directing, guiding and influencing the contributions of members to individual and group achievements ■ Directing takes place by means of the process of communication ■ Leaders give power to motivate employees in their task performance
The change process	■ Is seen by managers as a process according to which opportunities are selected, problems solved, and change accomplished.	■ The leader, as a dynamic force, stimulates, motivates and co-ordinates followers (nurses) in the organization towards change
Specific role within the organization	■ In their attitude to work managers aim for the attainment of organizational goals by relying on planning, budgeting, organizing, directing, controlling and other management tools, e. g. analysis of reports	■ Leaders ensure the attainment of organizational goals while facilitating healthy relationships among employees through free communication, utilisation of group dynamics, participative decision-making and motivation towards change ■ Risks are taken because they trust people and strive to motivate employees

Adapted from Jooste (1996b:160)

Managers have a service-providing function and they operate within the structured organizational hierarchy, while leaders operate in a more flexible uncontrolled continuum (Jooste1996b:160). Table 2.1 illustrates differences between management and leadership.

A paper by Wilderom (1991:6) discusses the difference between management and leadership in the service provision sector as compared to an industrial organizational setting. He shows that leadership and management seem to operate the same in industrial and service organizations, especially at top management level. This view is supported by Gapp (2002:338) who also places leadership and management at the same level as part of the management team of an organization. It can therefore be deduced that good managers should also possess leadership skills.

2.8 CONCLUSION

A theoretical framework for analysing factors that affect performance of staff was discussed. The frameworks and models by Bennett and Franco (1999:1); Sharpley (2002:2) and Nickols (2003:2) show evidence that social, cultural, organizational and individual factors affect staff performance. The Performance Model, illustrated in Figure 1.2, combines the various frameworks and models and presents variables and processes that influence performance of staff in an organization.

The literature study also looked at human resources for health, management and development. According to Hendry (1995:5), human resources are the most valuable assets of an organization. They are responsible for different interventions that have lasting competitive advantages for the organization. According to Effron, Gandossy and Goldsmith (2003:1), ‘Everything else in an organization can be replicated – products, services and infrastructure – but not people’.

The literature review further focused on the assessment and monitoring of performance which involves a number of activities that could provide evidence about the status of productivity or how an organization is performing as a whole.

The literature also looked at management competencies required by managers and leaders in an organization to effectively manage and guide staff. Another focus was on the management process, leadership traits and interpersonal relations.

The above studies substantiate the assumption that there is a relationship between level of performance of health workers and the many social, organizational and individual factors that affect work performance. The next chapter will describe the research methodology adopted for this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The preceding chapter established that various factors may positively or negatively affect the performance of health workers and particularly professional nurses. This chapter describes the research methodology that was applied to investigate factors that affect the performance of professional nurses. It includes the aims and objectives of the study, the research design, the description of the population and sample, the data collection tools and process for data collection, content of the instruments, validity and reliability of the instruments, pre-testing of data collection instruments and pilot study. Information about the data analysis procedures and ethical concerns is also provided.

3.2 AIMS AND OBJECTIVES

The study aims at providing a human resources management framework that can be used to monitor and manage changes in nurses' performance so as to improve the performance of professional nurses in Namibia.

The objectives of this study are to:

- Determine factors which positively and negatively affect the performance of professional nurses;

- Ascertain the skills and competencies of nurse managers in order to facilitate good performance by their subordinates;
- Propose strategies that could improve performance of professional nurses;

3.3 RESEARCH DESIGN

The study followed a quantitative research approach using an explorative and descriptive design. **Quantitative research** seeks to answer questions of how much and how many and is concerned with relationships (especially causal relationships) between variables (Polit & Beck 2004:169). It often takes the form of experiment, quasi-experiment or non-experimental design.

True experiments are ways of testing cause and effect relationships between variables. According to Polit and Beck (2004:169), the three attributes of experimental research are:

- Manipulation of independent variables (presume cause) in order to observe whether this has an effect on the dependent variable,
- Control over one or more experimental variables,
- Randomisation of subjects in a control or research group; this prevents the researcher from distorting results through systematic bias.

Quasi-experimental design does not have all the characteristics of the true experiment and lacks either randomised or control group characteristics.

Quasi-experiments involve manipulation of independent variables and can possibly test whether variables can be correlated.

Non-experimental design is used where some of the independent variables are amenable to manipulation. Non-experimental design includes descriptive research that investigates situations and relationships in variables without manipulation of independent variables (Polit & Beck 2004:198).

The survey method is a non-experimental approach whereby a group of people or a community is investigated. The advantage of the survey is that it offers insight into the situation studied (Varkevisser et al 1991:148). In this study, the survey method was used. It provided information that made it possible to gain insight into the various factors that affect the performance of professional nurses and nurse managers.

The **exploratory design** allows the use of questionnaires distributed to a large sample of the population and is therefore intent on finding facts which relate to the field of study (Couchman & Dawson 1995:40). This is very important, especially since no previous studies were done in Namibia on issues of performance.

According to Struwig and Stead (2001:7) and Polit and Hungler (1989:19), exploratory research probes more by allowing for an in-depth exploration of dimensions of the phenomenon existing in the present and links it to phenomena that happened in the past. In other words, the researcher is

investigating a current outcome by attempting to determine previous factors that caused it. According to Burns and Grove (1993:38), **descriptive research** enables a researcher to explore and describe a phenomenon in its real situation. It also allows the researcher to generate new knowledge of the subject by describing characteristics of persons, situations and the frequency with which certain phenomena occur. Descriptive studies also measure incidence rates, prevalence rates and relative risks (Polit & Beck 2004:192-193).

This study was led by a problem statement which guided and directed the exploration of the subject area, especially where there is a gap in the knowledge (Burns & Grove 2003:70). According to Polit and Beck (2004:85), problem statement articulates the nature, context and significance of the study problem.

The study was demarcated according to two criteria. Firstly, the factors that affect performance of nurses were determined in relation to human resources management activities and the organizational processes in selected public and private hospitals in Oshana, Otjozondjupa and Khomas regions.

Secondly, two groups of hospitals were selected: those with more than 450 beds and those with just over 100 beds. Those with more than 450 beds provided responses from a large number of nurses in teaching hospital situations.

3.4 POPULATION

The target population for this study constituted professional nurses in public and private hospitals within the boundaries of Oshana, Otjozondjupa and Khomas regions. According to Polit and Beck (2004:290), the target population "is the aggregate of cases about which the researcher would like to make generalisations".

3.4.1 Sampling

According to Polit and Hungler (1989:169), "...Sampling refers to the process of selecting a portion of the population to represent the entire population". The representative sample consists of subsets of the elements of a population; this allows for study results to be generalised (Polit & Beck 2004:290; De Vos et al 2005:194). The characteristics of the sample population are intended to be representative of the target population.

Sampling criteria, which is also referred to as 'eligibility criteria', involves listing of attributes essential to the study. The sampling criteria also consist of inclusion criteria which are characteristics the subject should have to be included in the study. Also important are exclusion criteria, that is characteristics that will exclude a subject from a study (Burns & Grove 2003:234). In this study the inclusion criteria consist of all professional nurses working in selected hospitals in the Oshana, Otjozondjupa and Khomas regions, including those who are in supervisory or managerial positions.

3.4.1.1 Sample design

The literature differentiates between two types of sampling: non-probability and probability. Non-probability sampling is used in large-scale surveys where the elements are not known and are thus non-random selection of subjects (Babbie 2005:188). The disadvantage of non-probability sampling is that it is a less representative approach. Four types have been identified: convenient, snowball, quota and purposive or judgmental (Polit & Beck 2004:311; Babbie 2005:196).

Probability sampling is seen as the best way of selecting a sample that is representative of the population from which it is drawn. In probability sampling, every element has an equal chance of being selected for the sample. Probability sampling allows for the calculation of the desired sample size for the margin of error the researcher will agree to (De Vos et al 2005:198; Polit & Beck 2004:311; Brink & Wood 2001:134). Four types of probability sampling are: systematic, simple random, stratified random and cluster (De Vos et al 2005:198; Polit & beck 2004:311; Babbie 2005:196; Brink & Wood 2001:140).

A stratified sample was used in this study. Professional nurses as category 1 and those professional nurses who are in supervisory or managerial positions referred to in the study as nurse managers as category 2, were randomly selected. This method was selected because it allowed for the population to be divided into two or more strata or groups. According to Varkevisser et al

(1991:200), random sampling ensures that units of the sample are selected on the basis of chance, and all units have an equal chance to be included in the sample.

3.4.1.2 Sample selection

The sample selection included all public and private hospitals with just over 100 beds and public hospital with more than 450 beds in Oshana, Otjozondjupa and Khomas region. The selection of these regions were based on the criteria that they comprised the 2 regional hospitals and 1 tertiary hospital in the country and thus employed the highest numbers of professional nurses. The other regions were excluded because of practical reasons: Professional nurses are scattered all over small hospitals and health centers in the urban and rural areas, with ineffective or no postal services; cost constraints for hiring data collectors to reach these remote regions

The selected hospitals represents, 75 percent of hospitals in the sampled region and include one national referral hospital, two intermediate regional hospitals, two district hospitals and one private hospital (Table 3.1). Professional nurses and nurse managers working in these hospitals were requested to participate in the study (Table 3.2).

Table 3.1: Hospitals sampled in Oshana, Otjozondjupa and Khomas regions

REGION	HOSPITALS	POPULATION	SAMPLE
Oshana	Oshakati Intermediate Hospital*	2	2
	Onandjokwe District Hospital*		
Otjozondjupa	Grootfontein**	2	1
	Otjiwarongo Hospital**		
Khomas	Katutura Intermediate Hospital*	3	3
	Windhoek National Referral Hospital*		
	Roman Catholic Hospital**		
TOTAL		**7**	**6**

* Hospitals with over 450 beds

** Hospitals with just over 100 beds

From category 1, a 23.4 percent sample was taken to represent professional nurses (Table 3.2). From category 2, a 28.6 percent sample represented nurse managers. Because the population of nurse managers is significantly smaller than that of professional nurses, a larger sample percentage was selected to ensure a meaningful statistical analysis (Brink & Wood 2001:144).

Table 3.2: Categories of respondents

CATEGORY	POPULATION	SAMPLE n (%)
Category 1 (professional nurses)	770	180 (23.4)
Category 2 (nurse managers)	210	60 (28.6)
Total	**980**	**240 (24.0)**

According to De Vos et al (2005:195), large samples allow for drawing more representative and accurate conclusions and generalisations. In other words, the larger the sample, the smaller the sampling error. Generalisation is a very important aspect in the results of a study. It extends the study results to the larger population. However, small samples may not provide enough scope for generalisation. According to De Vos et al (2005:195), small sample size can impact on statistical tests and can make them insensitive or over-sensitive.

Another aspect of sampling is bias. According to Polit and Beck (2004:291), sampling bias refers to the systematic over- or under-representation of some segments of the population in terms of characteristics relevant to the research questions.

With regard to estimating the correct size of a sample, Seaberg (1988) and Grinnel and Williams (1990) as quoted by De Vos et al (2005:195) stated that a 10 percent sample should be sufficient to control any sampling errors. Apart from selecting samples based on percentage, another way of estimating the correct size of a sample is through the use of a power analysis, a method of estimating that the sample is large enough to assume that the statistical analysis is meaningful and large enough for detecting errors (Brink & Wood 2001:144).

Simple random sampling was used to select the sample. The process of selecting the sample involved the following:

- Staff establishment from the selected hospitals were acquired before hand.
- Two numbered lists of names (for professional nurses and for nurses managers) were developed from the staff establishment.
- Those who were on leave for the month were excluded from the list.
- A table with random numbers were established and numbers were randomly selected.
- The names corresponding to the numbers selected were included in the sample (Burns & Grove 2003:241; Brink & Wood 2001:137).

3.5 INSTRUMENTATION

Data collection, in this study, refers to gathering information for research purposes. Data may be collected through a variety of methods using the appropriate instruments (Mouton 2001:105).

For this study, data were collected with questionnaires which served as the most appropriate instruments. Two structured self-administered questionnaires, one for professional nurses (appendix 6) and one for nurse managers (appendix 7), were designed for collecting and recording data. The questionnaire for professional nurses consisted of 105 items, and the second questionnaire consisted of 126 items. Both questionnaires took approximately 15 to 25 minutes to complete. The questionnaires had some similar content, but some questions differed. For

example, the nurse manager questionnaires probed for specific information regarding supervisory and management functions.

According to De Vos et al (2005:166), questionnaires are the most frequently used data collection instrument. A questionnaire is a collection of questions based on the subject of interest to the researcher and completed by respondents. Questionnaires are also called *surveys for quantitative research* and are sometimes referred to as *survey research* (Burns & Grove 2003:289).

The questionnaire was used because it is the simplest and least expensive method of obtaining information from large numbers of subjects. It permits anonymity and may result in more honest responses. It eliminates bias due to phrasing questions differently for different respondents, since the researcher is not present. If well-designed, questionnaires collect accurate data. The disadvantage is that questionnaires depend on personal reporting and therefore may be biased or inaccurate (Enarson et al 2001:79; Burns & Grove 2003: 289; Brink & Wood 2001:159).

3.5.1 Design of questionnaires

After completion of the literature review, the two questionnaires (hereafter referred to as questionnaire 1 and questionnaire 2) were developed for the study. The general aim of both questionnaires was to identify factors that positively and negatively affect performance of health workers and obtain the views of professional nurses and nurse managers on how to guide the identification of

strategies to improve their performance. In addition, questionnaire 2 was to ascertain the skills and competencies of nurse managers in order to facilitate improved performance by their subordinates.

The design of the structured questionnaire was guided by the objectives, the literature review and the performance model as indicated under item 2.2.3. There were open-ended and closed questions. The open-ended questions allowed respondents to be spontaneous while presenting their perceptions and viewpoints in their own words (Struwig & Stead 2001:92).

Most questions were closed questions except open-ended questions 11, 16, 57, 58 and 59 (questionnaire 1 and questionnaire 2) and questions 9 and part of 10 (questionnaire 2). Questions 1 to 8 (questionnaire 1) and questions 1 to 6 (questionnaire 2) required respondents to make a choice from the personal and organizational demographic elements listed. Response alternatives of *very poor, poor, average, good* and *excellent* were applicable to questions 9 to 11 (questionnaires 1 and 2), with the exception of questions 7 and 9 where a *No* or *Yes* response was requested.

A rating scale with four or five response alternatives was used to measure opinion, reaction and attitude in relation to the statement given, in particular the Likert scale was used (Burns & Grove 2003:292). The alternative responses were *strongly disagree*, *disagree*, *uncertain*, *agree* and *strongly agree*. This scale applied to questions 14, 15, 17, 18, 19 and 20-53 (questionnaire 1) and questions 11, 13, 14, 16, 17, 18 and 20 to 53 (questionnaire 2). A four-response alternative

scale was used for question 19 (questionnaire 2) which was *do not know***,** *do not agree, tend to agree* and *fully agree***.**

3.5.2 Content of questionnaires

The two questionnaires were divided in to four sections as depicted in Table 3.3.

Section A

Questions 1 to 4 (questionnaires 1 and 2) requested the respondent for personal information with regard to age, gender, highest qualification and number of years as a registered nurse. Respondents were requested to make a choice from the listed elements.

Section B

Section B requested respondents to make choices on what is applicable to them in relation to organizational demographics. Questions 5 to 8 (questionnaire 1) and questions 5 and 6 (questionnaire 2) attempted to determine the type of hospital, status of employment, the discipline they worked in as well as the duration of their current placement in that discipline, and the current position held.

Section C

Questions 7 and 8 (questionnaire 1) and question 11 (questionnaire 2) were included to determine the skills and knowledge of respondents. Aspects included were skills for planning and implementation of nursing services policies and plans providing in-service training to subordinates and health education to patients.

Skills were determined regarding development and implementation of nursing performance standards, performance appraisal and interviews for performance outcomes, management of conflict and counseling of patients and employees (Rafferty et al, 2005:31; Price 2000:26; WCPS 2001:52; Jooste 1996b:285).

Question 7 (questionnaire 2) tried to determined the experience or involvement of respondents in important management activities such as discussion of performance outcomes with subordinates, staff training, management of conflict, orientation, counseling of employees and research (Rafferty et al 2005:31; WHO 2006:74; Armstrong 1994:132; Swansburg & Swansburg 1999:571; Booyens 1993b:362).

Questions 12 and 13 (questionnaires 1 and 2), and question 14 (questionnaire 1) were formulated to determine whether performance appraisal is done in the wards, what methods are used, and how the results of performance outcome are used. The questions attempted to determine if performance is appraised according to known and agreed objectives, if feedback of outcomes is discussed and what role the manager played in supporting and motivating subordinates (Bennett & Franco 1999:8; Zurn et al 2004:3; Nickols 2003:2; Price 2000:8; Swansburg & Swansburg 1999:480; Martineau 2005:7; Armstrong 1994:1; Torrington & Hall 1998:317; Troskie 1993:534; Hornby & Forte 2002:1).

Questions 9 and 10 (questionnaire 2) attempted to determine whether respondents received management and related training, what type of training and

if training was sufficient (Armstrong 1994:30; Daft & Noe 2001:20; Homer 2001:61).

Question 14 (questionnaire 2), and questions 15, 16, 17, 18, 19 (questionnaires 1 and 2) attempted to determine the opinion of respondents with regard to remuneration and benefits practices, working and employment conditions, workspace and environment, work schedule and leadership and management style (Sirota 2002:5; Hicks & Adams 2003:258; WHO 2000:11; Bezuidenhout 1994:46; Daft & Noe 2001:192; Jooste 1996b:159; Wilderom 1991:6; Gapp 2002:338).

Section D

The last section, D, comprising of questions 20 to 59 (questionnaires 1 and 2) was included as an organization opinion survey to determine the view of the respondents about the organization they work in. The questions covered a broad range of subjects that included the organization's mission and goals, reward and recognition, commitment and satisfaction, interpersonal information, social and cultural factors and management style (Franco & Bennett 1999:4; Nickols 2003:2; Sharpley 2002:2).

Questions 57 to 59 were open-ended questions and requested information about what respondents like most and least about working for the organization and to indicate what they would most like to see improved.

Table 3.3: Content of questionnaires

SECTIONAL CONTENT	QUESTIONS	
	QUESTIONNAIRE 1	QUESTIONNAIRE 2
Section A: Personal Information	1-4	1-4
Section B: Organizational demographics	5-8	5-6
Section C: Knowledge base and human resources management issues	9-19	7-19
Section D: Organization processes	20-59	20-59

3.5.3 Reliability and validity of instruments

Validity and reliability are the most important criteria for evaluating quantitative instruments. The reliability of instruments was measured using the Cronbach's Alpha.

3.5.3.1 Reliability

According to Polit and Beck (2004:416), "...reliability is the consistency with which the instrument measures the target attribute". This means that administering the same instrument by various researchers will provide the same results under comparable conditions (De Vos et al 2005:163). *Reliability* of an instrument can be equated to clarity, quality, stability, consistency, adequacy and accuracy of the measuring tool (Polit & Hungler 1989:242; Varkevisser et al 1991:152).

According to Garson (2006a:1) reliability can be estimated in one of the following four ways which is *internal consistency*, *split-half reliability*, *test-retest reliability* and *inter-rater reliability*. In this study, reliability of different items of the instrument was tested by means of the Cronbach's Alpha which is the most common means of testing internal consistency of the items, using the SPSS package.

Internal consistency reliability refers to the extent to which all the subparts of an instrument will measure the identified attributes. By rule a lenient cut-off of .60 is common in exploratory research; the alpha should be at least .70 or higher to retain an item in an adequate scale (Garson 2006a:2). For most of the items in this study, the reliability test was found to be adequate (appendix 9 and 10). However items under themes such as interpersonal relations, performance, commitment and satisfaction have been found to be below .60. Factor analysis was done for these themes to identify the items that may not be consistent with the themes within each category.

3.5.3.2 Validity

Validity refers to 'the degree to which an instrument measures what it is supposed to be measuring'. In other words, a valid instrument actually measures the concept it is supposed to measure (Polit & Hungler 1989:246; Varkevisser et al 1991:151; De Vos et al 2005:160). According to Polit and Beck (2004:41) and De Vos et al (2005:60), three main approaches for assessing the validity of instruments designed to collect quantitative data are content validity, criterion-related validity and construct validity.

In this study, construct and content *validity* was used to assess the validity of the instruments by means of assessing the adequacy, appropriateness, inclusiveness and relevancy of the questions to the subject under study was assessed.

Content validity of an instrument means validating the fact that the instrument designed does represent the factors under study, and this is substantiated by the study (Garson 2006b:4). Experts in the specific study field were called upon to judge whether or not the instrument reflects the known content area (De Vos et al 2005:161; Brink & Wood 2001:179; Burns & Grove 2003:274-275). *Face validity* is a subtype of content validity and is not a technical validation. It merely establishes that the tool 'appears' to measure the variables in the content. In other words, it does not examine whether an instrument actually measures what it is expected to measure (De Vos et al 2005:161; Brink & Wood 2001:178).

3.5.4 Pre-testing of data collection instrument

Instruments were field tested prior to the use of the final document. Copies of the provisional questionnaires were given to eight people—experienced professional nurses, human resources management experts, academic experts in nursing and a statistician—who examined each item of the questionnaires in relation to others and helped to refine the document. Pre-testing allowed for modification of the design of the questions, sensitivity of language, rephrasing of questions and estimation of the time necessary for completing the questionnaire.

A cover document accompanied the questionnaires indicating the title, the aims and objectives of the study (appendix 8) to enable experts to evaluate the content and items against the study. After proposing some changes, there was consensus amongst these experts that the instrument was valid for the study to commence (De Vos et al 2005:209).

3.6 PILOT STUDY

After permission was received from the relevant authorities, a pilot study was carried out at two hospitals involving eight professional nurses and four nurse managers. These hospitals were not involved in the major study.

According to Burns and Grove (2003: 42), a pilot study is often defined as "...a smaller version of a proposed study, and is conducted to refine the methodology". A pilot study allows the researcher to test the prospective study and is done on a small number of people having characteristics similar to those of the target respondents. The pilot study helps to identify possible problems in the proposed study and allows the researcher to revise the methods and instruments before the actual study, in other words to improve the success and effectiveness of the study (De Vos et al 2005:206; Varkevisser et al 1991:265).

According to De Vos et al (2005:210) the pilot study offers an opportunity for:

- Assessing the suitability of the interview schedule or questionnaire,

- Testing and adapting the measuring instruments such as assessment scales, standard scales for sufficiency, validity and reliability,
- Determining the suitability of the procedures for collecting data,
- Testing the suitability of the sampling frame,
- Determining the number of codes per question and making necessary changes prior to the study,
- Estimating the amount of time for completing the questionnaire or interview schedule.

As depicted in table 3.4, three hospitals were considered for the pilot study at the same time as the selection of the sample took place. Unfortunately only two hospitals were ready to carry out the pilot. Eight questionnaires for professional nurses and four for nurse managers (appendices 6 and 7) accompanied by a covering letter (appendix 8) explaining the purpose of the pilot study were personally delivered to the pilot hospitals. The respondents were asked to give constructive feedback with regard to comprehension, clarity of questions and time necessary to complete the questionnaires.

Table 3.4: Pilot study responses

QUESTIONNAIRES	NUMBER SENT	NUMBER RETURNED	% RETURNED
Questionnaire 1	8	8	100
Questionnaire 2	4	4	100
Total	**12**	**12**	**100**

The respondents made corrections on the types of hospitals (question 5) and different nursing positions (question 6). They did not experience difficulty in completing the questionnaires; however, they mentioned that answering questions 35-56 required careful consideration and thinking. It was mentioned that completion of questionnaires took between 15 and 25 minutes. The necessary amendments were made to questions 5 and 6 before printing the questionnaires.

3.7 DATA COLLECTION

Initial contact was initiated to meet with nurse managers and respondents, taking into account some of the problems associated with data collection: The possibility of questionnaires being sent in incomplete and misunderstanding of items and non-return of questionnaires were problems that were foreseen (De Vos at al 2005:212).

To counteract these negative aspects, the questionnaires together with a return envelope were delivered personally by the researcher to the nursing manager of each hospital. (Burns & Grove 2003:299). During these visits, the aim, importance of the study and questionnaire return dates were explained.

3.8 DATA ANALYSIS

Data analysis refers to "...the systematic organization and synthesis of research data, and the testing of research hypotheses" (De Vos et al 2005:716). Data analysis gives meaning to data collected during research (Burns & Grove 2003:479).

A total of 189 completed questionnaires (147:81% of questionnaire 1 and 42:70% of questionnaire 2) were received and coded before and until the final date. Each questionnaire was scrutinised by the researcher to examine the response pattern and identify abnormalities in the completion of questionnaires. The statistical analysis program SPSS was used to analyse the data.

Descriptive statistics that include frequencies and percentages were used for analysis of data. For the open-ended questions, data were organised under thematic categories and used in the discussions to support results from the close-ended questions (Polit & Beck 2004: 145; Burns & Grove 2003: 325).

3.9 PERMISSION TO CONDUCT RESEARCH

Permission was acquired from the Permanent Secretary, Ministry of Health and Social Services (Appendix 3) to conduct research in all government hospitals. Even though permission for the study was granted, the medical superintendents of the selected hospitals had to approve the time period for distribution of the

questionnaires. Letters for permission were therefore forwarded to all the selected hospitals, with a copy of the permission letter from the Permanent Secretary**.**

Responses from all selected hospitals were positive. With regard to private hospitals, only one hospital fell within the criteria of the sample. Permission was granted by the management of the private hospital, and the medical superintendents of the five public hospitals agreed to the timeframe for collecting data.

3.10 ETHICAL CONSIDERATIONS

According to De Vos et al (2005:57), the term *ethics* mean "...preferences that influence behaviour in human relations". Ethics is mostly associated with morality and deals with issues of right and wrong among groups**,** society or communities. It is therefore important that everyone who is dealing or involved in research should be aware of the ethical concerns (Babbie 2005:61). The following ethical issues, though not exhaustive, has been identified by various authors as important to be considered during any research: Informed consent, avoidance of harm, violation of privacy, anonymity and confidentiality, deceiving respondents or concealing of information, respect for human dignity that include right for full disclosure, debriefing respondents and presentation and interpretation of data. (De Vos et al 2005:58: Polit & Beck 2004:144).

With regard to this study, the aims and objectives were conveyed to all the relevant authorities during the process of acquiring permission to do research, and to the nurses and managers involved during the data collection stage.

Respondents were told that their participation was voluntary and that they had the right to withdraw from the study at any time if they so wished. Anonymity and confidentiality were promised and ensured, by providing a self-addressed return envelope with each questionnaire and by requesting respondents not to write their names on the questionnaire. In addition, a covering letter which explained the aim and objectives of the study accompanied each questionnaire.

3.11 CONCLUSION

This chapter discussed the research design, population, sample and sampling design. Data collection instruments, the data collection process, pre-testing of the data collection tools, validity and reliability of data collection instruments were also discussed. Furthermore, permission for research, pilot testing and ethical considerations were considered.

The next chapter will deal with analysis and interpretation of the results acquired from questionnaire 1 (professional nurses) and questionnaire 2 (nurse managers).

CHAPTER 4: DATA ANALYSIS

4.1 INTRODUCTION

This chapter presents the views of the respondents regarding factors which positively and negatively affect the performance of professional nurses and nurse managers in the Oshana, Otjozondjupa and Khomas regions.

The main objectives of the study were to:

- Determine factors that positively and negatively affect the performance of professional nurses;
- Ascertain the skills and competencies of nurse managers in order to facilitate good performance by their subordinates;
- Propose strategies that could improve performance of professional nurses;

The findings are organised in relation to the two questionnaires that directed the study. Questionnaire 1 was directed to professional nurses, while questionnaire 2 was directed to professional nurses who are supervisors in clinical wards or in management positions and referred to as nurse managers. The hospitals sampled were public hospitals which included a national referral hospital, two intermediate regional hospitals and two district hospitals; one private hospital was also included.

Although initially comparison between data from private and public hospitals were desired to be made, this was found not to be feasible afterwards. It was

found that the private hospitals in the selected regions could not meet the criteria set (over 100 beds) for selection of the sample hospitals and that the numbers of respondents from the private hospital were too small and thus comparison was not seen as useful. The results therefore were considered whether they came from private or public hospitals.

All questions were not answered by all respondents; therefore, the frequencies indicated in tables and figures are often less than the total number of respondents. Therefore if all respondents answered a question the total number of the sample, for example 147 (questionnaire 1) and 42 (questionnaire 2) was indicated. However, if the number of respondents were less the actual figure was indicated as the n= value and missing values are noted.

Due to the rounding off of individual percentage to one decimal point in subsequent tables and figures, the total cumulative percentages might not add up to exactly 100.0 in all cases. The resultant error is however never larger than 0.01 percent.

4.2 PERSONAL INFORMATION

A brief personal profile of the respondents is provided in this section. This information was obtained from Section A of the questionnaires. Personal information includes respondents' age, gender and highest qualifications.

4.2.1 Respondents

The respondents for questionnaire 1 were professional nurses working in clinical wards, while questionnaire 2 was directed to nurse managers or supervisors in clinical wards. Of the 240 questionnaires distributed, 189 were returned by the respondents. For questionnaire 1, 147 were returned, and 42 were returned for questionnaire 2, resulting in a response rate of 81.6 per cent for questionnaire 1 and 70.0 per cent for questionnaire 2.

Table 4.1: Questionnaires sent out and returned

QUESTIONNAIRES	**NUMBER SENT OUT**		**NUMBER RECEIVED**	
	n		**n**	
Group 1 (Questionnaire 1, professionnel nurses)	180	75.0	147	81.6
Group 2 (Questionnaire 2, nurse managers)	60	25.0	42	70.0
Total	240	100.0	189	78.75

Table 4.1 indicates the general response rate for the respective questionnaires, providing a combined response rate of 78.75 percent, which is considered to be very good (Polit & Beck 2004:300).

4.2.2 Age of respondents

The age of respondents is an important aspect during the interpretation of results.

Figures 4.1 and 4.2 present the results regarding the age distribution of respondents.

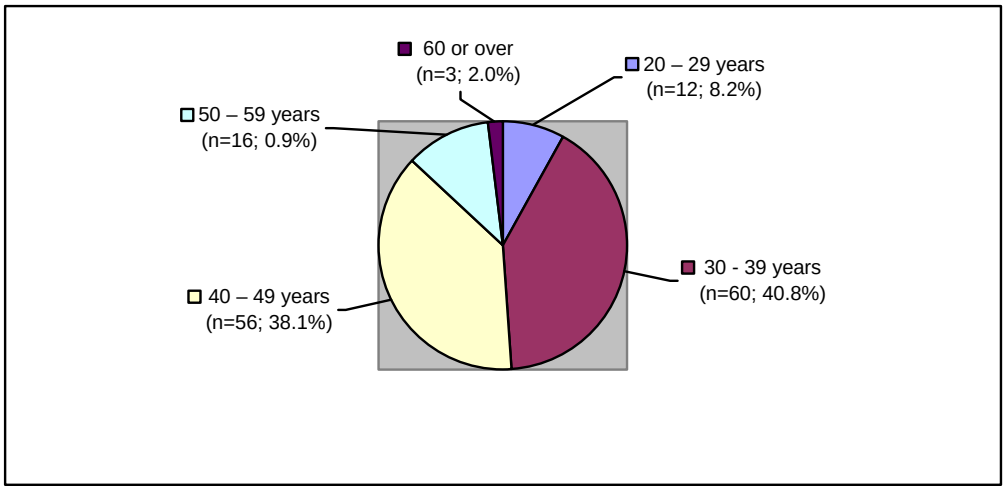

Figure 4.1: Age category of professional nurses (n=147)

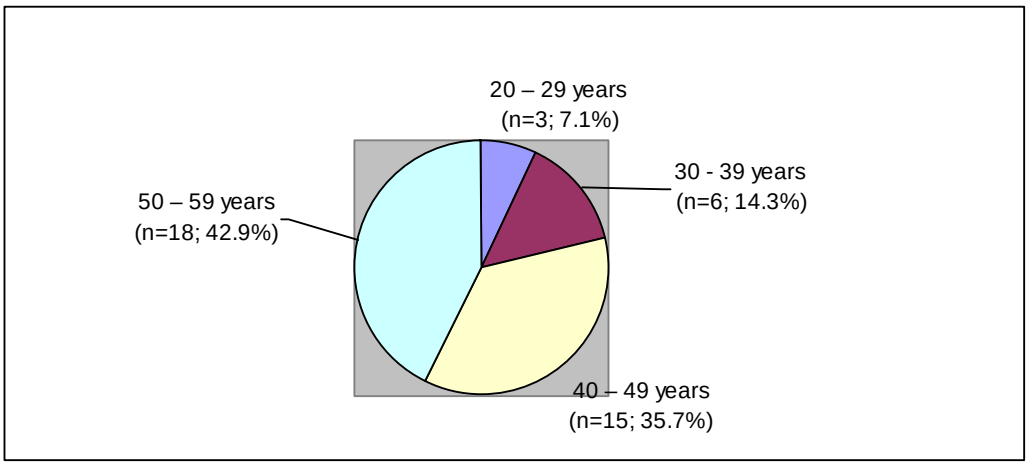

Figure 4.2: Age category of nurse managers (n=42)

The age distribution of both groups of respondents indicated that the nurse managers in general were about a decade older than the professional nurses. Almost three quarters of the professional nurses (116; 78.9%) were between the ages of 30 and 49 years, while over three quarters of the nurse managers (33; 78.6%) were between 40 and 59 years.

4.2.3 *Gender of respondents*

Although the nursing profession in Africa is female-dominated, it is important to see how many male respondents participated in the study to determine if they will provide any significantly different views from the female respondents. Figure 4.3 presents data regarding the gender of the respondents.

The data revealed that the nurse population is dominantly female as 138 (93.9%) professional nurse respondents and 41 (97.6%) nurse managers are female. This correlates with the *Namibian Nursing Board's Statistics 2004* which indicate that 97 percent of nurses in Namibia are female and the literature that indicates that the nursing workforce in the health sector is mostly female (WHO 2002c:33).

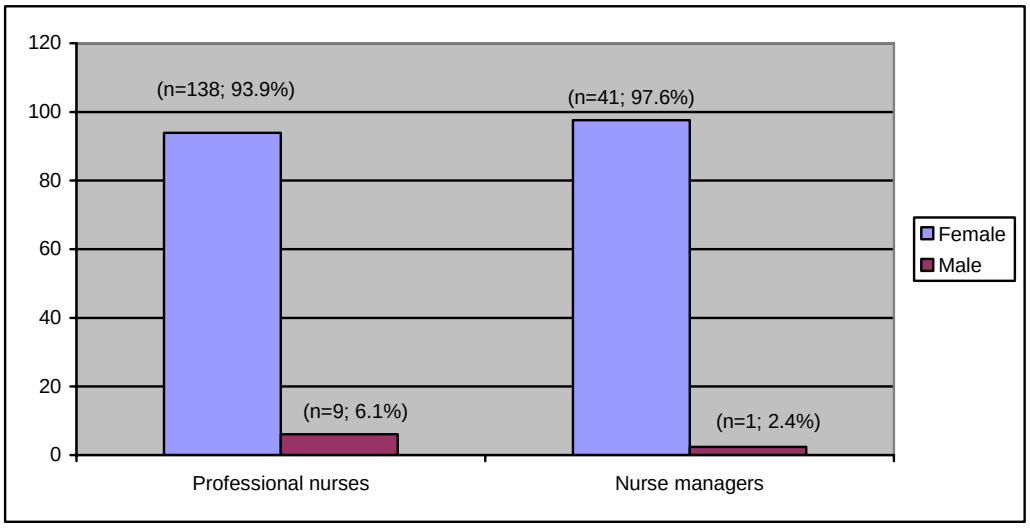

Figure 4.3: Gender of professional nurses (n=147) and nurse managers (n=42)

4.2.4 Highest nursing qualifications

In an attempt to ascertain respondents' academic qualifications and thus the skill base, respondents were requested to provide their highest nursing qualification obtained. Figures 4.4 and 4.5 present the results pertaining to the highest qualification of respondents.

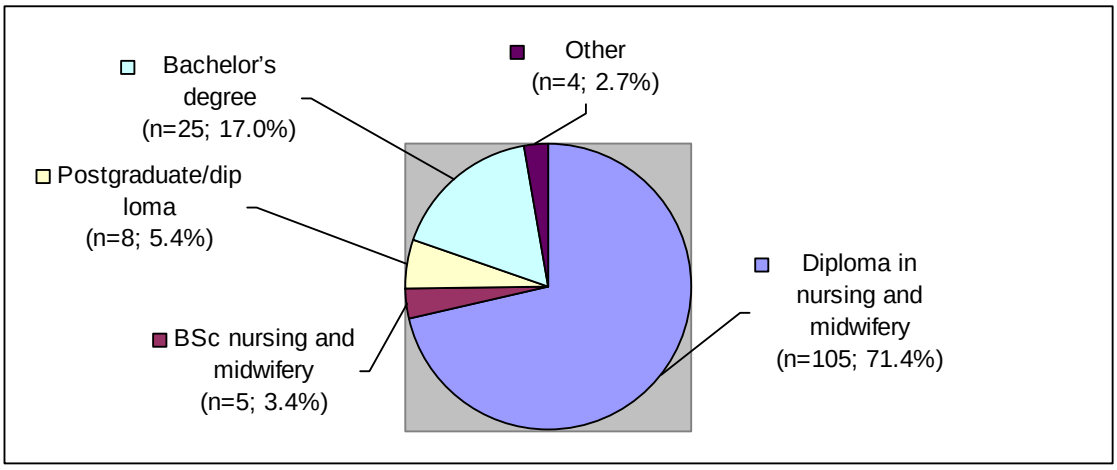

Figure 4.4: Highest nursing qualification for professional nurses (n=147)

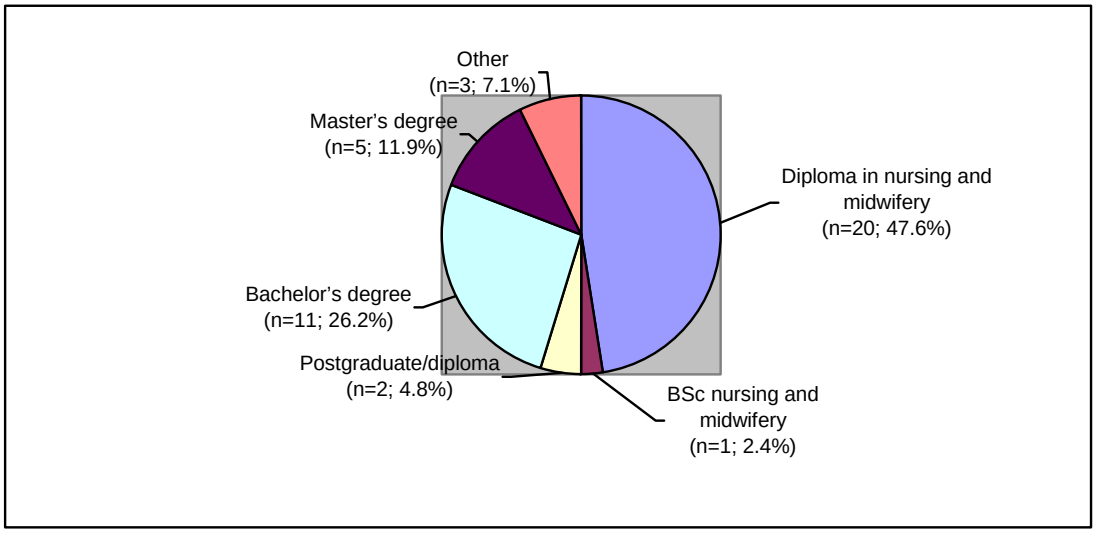

Figure 4.5: Highest qualifications for nurse managers (n=42)

The majority of professional nurse respondents (105; 71.4%) reported having the first diploma in nursing and midwifery as their highest qualification, while 25 (17.0%) have a Bachelor's degree as indicated in Figure 4.4. It is, however, disconcerting that less than a third (11; 26.2%) of the nurse managers have a Bachelor's degree while five (11.9%) have a Master's degree as indicated in Figure 4.5. It can be assumed that nurse managers may have clinical experience but lack competencies which are expected from someone at managerial level. Swansburg and Swansburg (1999:37) emphasised the importance of nurse managers in clinical units to be educated at Master's level to be able to understand the concepts and theories for managing nursing services.

4.2.5 Years registered as a professional nurse

Figures 4.6 and 4.7 consist of data concerning the responses of professional nurses and nurse managers about the length of time they have been registered as nurses.

The extensive experience of professional nurses and nurse managers correlates with their ages as provided in Figure 4.1 and Figure 4.2. Over half (89; 60.5%) of professional nurses had 6-15 years of experience while less than three quaters (28; 66.7%) of the managers had 16-21 years and longer experience as professional nurses, which provides a solid background for nursing activities and the management of human resources in the units or wards.

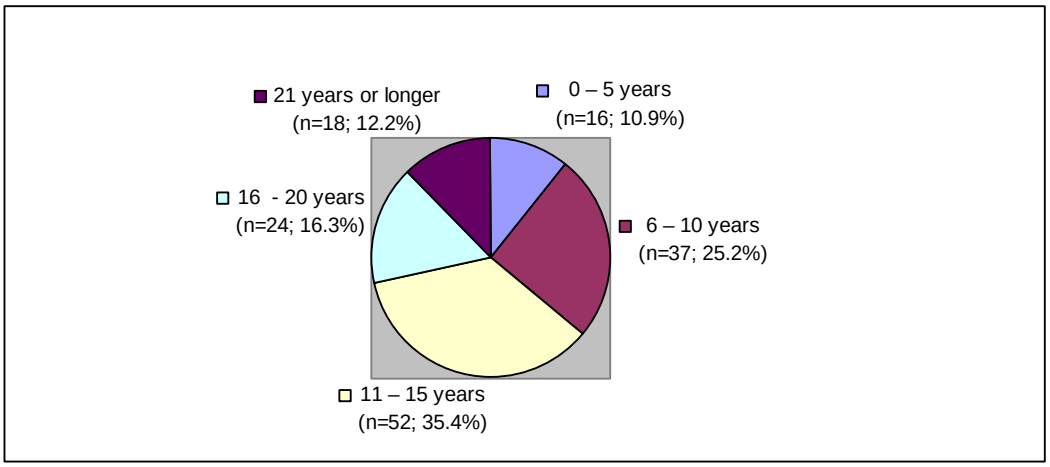

Figure 4.6: Number of years registered as professional nurses, group1 (n=147)

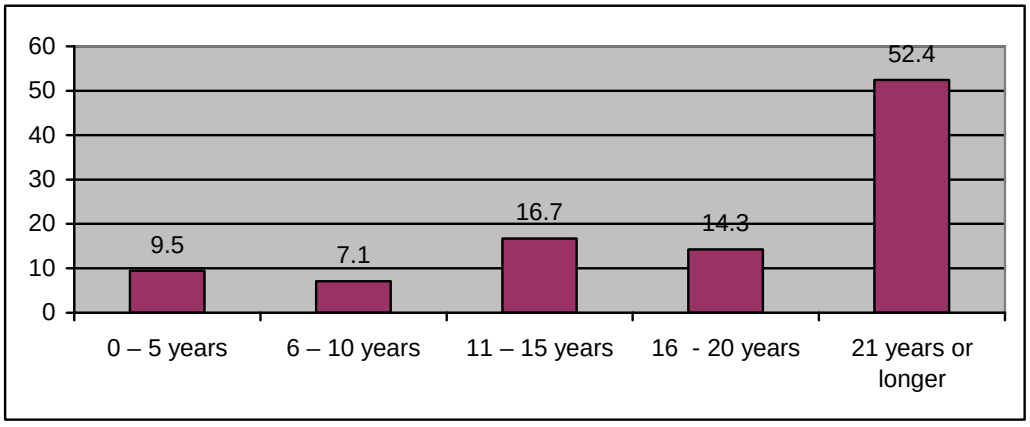

Figure 4.7: Number of years registered as professional nurse, group 2 (n=42)

4.2.6 Organizational demographics

This section provides organizational demographic data which were obtained from Section B of the questionnaire. It consists of data about the type of

hospital, their discipline, the duration of time they worked in the discipline and position held by nurse managers.

Figures 4.8 and 4.9 present data on the types of hospitals in which nurse managers and professional nurses are working.

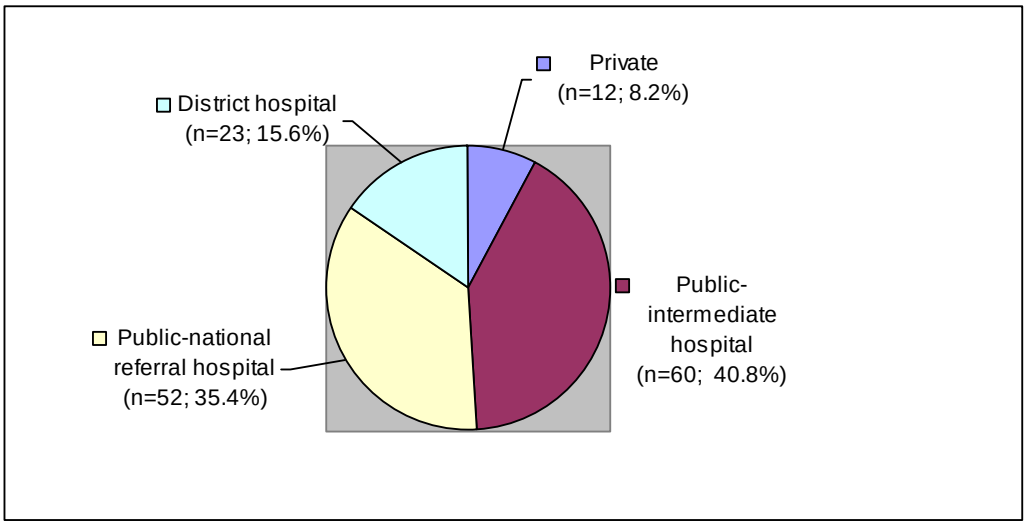

Figure 4.8: Type of hospitals in which professional nurses are working (n=147)

The majority of professional nurses worked in public-intermediate hospitals (60; 40.8%) and public-national referral hospitals (52; 35.4%), while 23 (15.6%) worked in district hospitals and 12 (8.2%) were from private hospital as indicated in figure 4.8.

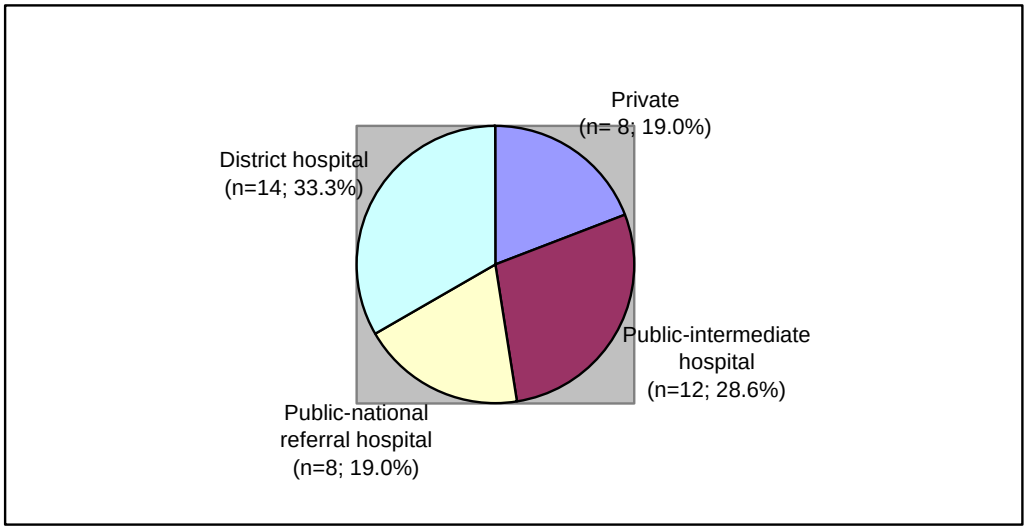

Figure 4.9: Type of hospitals in which nurse managers are working (n=42)

The majority of nurse managers worked in district hospitals (14; 33.3%) while less than a third worked in public-intermediate hospitals (12; 28.6%). Eight (19.0%) were worked in the public-national referral hospital while 8 (19.0%) were from private hospitals as indicated in figures 4.8 and 4.9. This is in line with the sample design where only one private hospital was included in the study.

Table 4.2: Employment status of professional nurses (n=147)

Employment status	**n**	**%**
Full-time	146	99.3
Part-time	1	0.68
Total	147	100.0

The majority (99.3%) of the professional nurse respondents were in full time employment while only one (0.68) respondent did part time work.

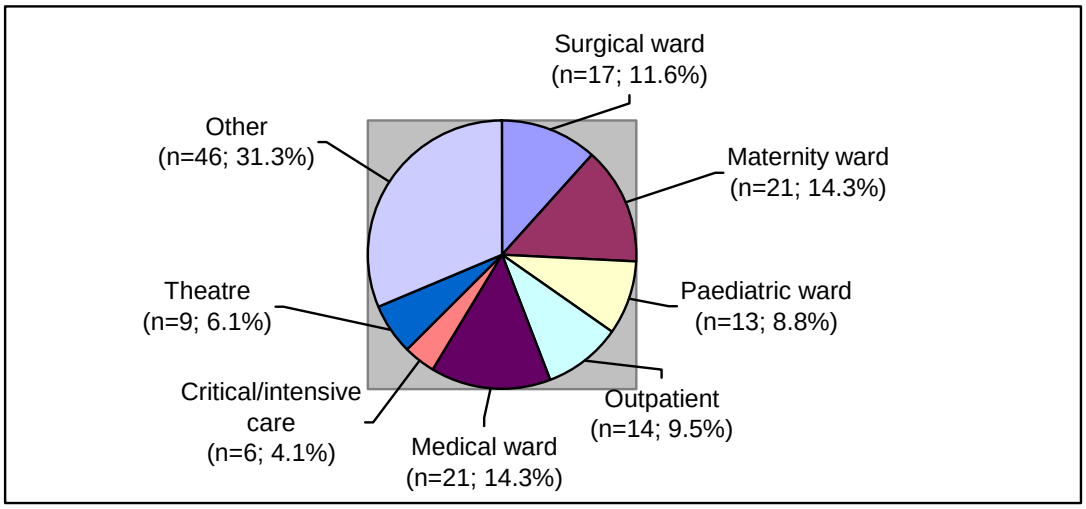

Figure 4.10: Type of discipline or clinical ward where professional nurses work (n=147)

Figure 4.10 consist of data concerning the type of clinical wards or units where professional nurse respondents work. The data revealed that professional nurses worked in different types of wards and units: maternity wards (21; 14.3%), medical wards (21; 14.3%) and surgical wards (17; 11.6%). It can be concluded that professional nurses work in different disciplines, environments and workplaces.

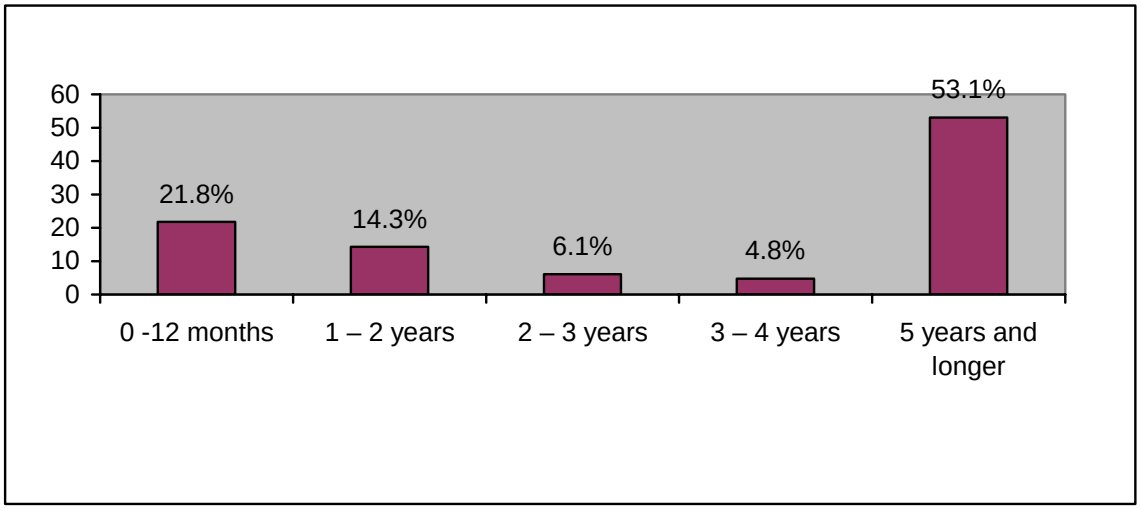

Figure 4.11: Number of years professional nurses have worked in specific ward (n=147)

Just more than half of the respondents (78; 53.1%) have worked in their wards for 5 years and longer, this gives them experience on issues pertaining to that specific ward, while less than a third (32; 21.8%) worked in their specific wards for 12 months or less as indicated in Figure 4.11.

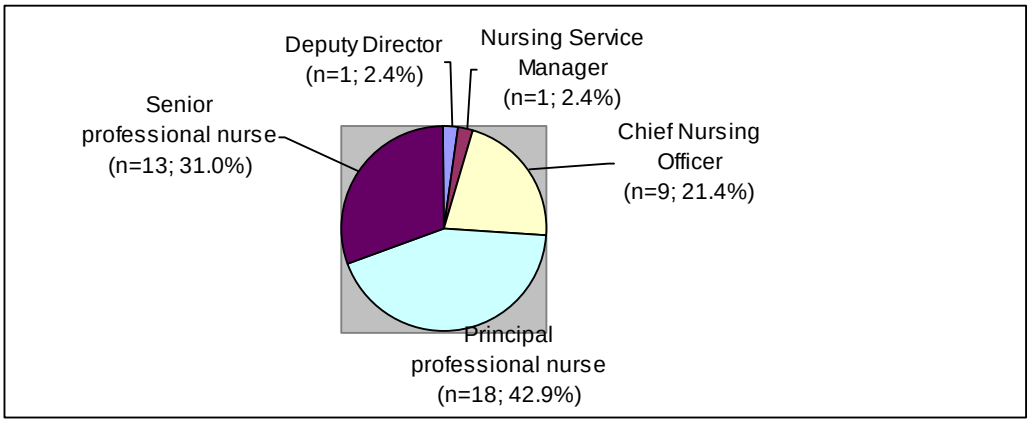

Figure 4.12: Nurse manager positions held (n = 42)

In Figure 4.12, less than half (18; 42.9%) of nurse managers are principal nurse managers, while almost a third (13; 31.0%) are senior professional nurses. Less than a third (9; 21.4%) are in chief nursing officer posts. It is assumed that although the majority of nurse managers (35; 83.4%) have worked as registered nurses for 11 to 21 years and longer, they are at the lower grade of nurse manager positions. This brings out the question of upward progression or the availability of career development programmes.

4.3 RESULTS OF QUESTIONNAIRE 1

The purpose of this section is to present the information obtained from questionnaire 1 as guided by the objectives of the study (as indicated in Section 4.1). The statistical information presented was gained from 147 questionnaires completed by professional nurses.

For the sake of discussion of Table 4.3, the values attributed to *very poor* and *poor* were grouped together and considered as unsatisfactory, whereas the *good* and *excellent* values combined were noted as satisfactory. With regard to the rest of the tables that have the values attributed to *strongly disagree* and *disagree,* the percentages were grouped together for discussion. Likewise, cumulative percentages were used for the values attributed to *agree* and *strongly agree*.

4.3.1 Aspects related to skills and knowledge of professional nurses

This section attempts to ascertain the level of knowledge and skills of professional nurses for implementation of the goals of the organization. Respondents were asked to assess their knowledge and skills as used in their current job positions according to five alternative ratings as indicated in Table 4.3.

The majority of professional nurses indicated their knowledge and skills as satisfactory. Nursing audit got the highest score (125; 86.3%), followed by planning of nursing care (123; 85.4%), interpersonal relations (112; 78.8%), implementing of nursing care plans (113; 77.9%) and implementing of nursing performance standards (107; 75.9%). It is disconcerting to find that quite a number of respondents rated themselves as *average* in the following skills: providing in-service training (50; 34.7%), patient counselling skills (45; 31.3%) self assessment with regard to outcome of performance (35; 24.5%), and improvement of quality (32; 21.9%).

It can be concluded that not all professional nurses have the required skills that will allow them to provide effective nursing care and guide student nurses' practical learning in the clinical environment. These are very important skills that professional nurses need to have, especially since most of the hospitals involved in the study are teaching hospitals and students are posted there for clinical experience (Martinez 2003:224).

Table 4.3: Professional nurse responses on aspects related to knowledge and skills (n=147)

RATING OF KNOWLEDGE AND SKILLS		VERY POOR	POOR	AVERAGE	GOOD	EXCELLENT	TOTAL*
Planning of nursing care.	n	4	1	16	93	30	144
	%	2.8	0.7	11.1	64.6	20.8	100.0
Implementing nursing care plans.	n	2	3	27	83	30	145
	%	1.4	2.1	18.6	57.2	20.7	100.0
Nursing audit.	n	0	1	19	72	53	145
	%	0.0	0.7	13.1	49.7	36.6	100.0
Implementing of nursing performance standards.	n	0	3	31	78	29	141
	%	0.0	2.1	22.0	55.3	20.6	100.0
Health education.	n	3	5	15	74	48	145
	%	2.1	3.4	10.3	51.0	33.1	100.0
Clinical competencies.	n	0	2	29	78	36	145
	%	0.0	1.4	20.0	53.8	24.8	100.0
Interpersonal relations.	n	2	2	26	77	35	142
	%	1.4	1.4	18.3	54.2	24.6	100.0
Patient counselling skills.	n	5	5	45	66	23	144
	%	3.5	3.5	31.3	45.8	16.0	100.0
Self assessment with regard to outcome of performance.	n	0	1	35	85	22	143
	%	0.0	0.7	24.5	59.4	15.4	100.0
Supervision of nursing care.	n	0	5	19	90	32	146
	%	0.0	3.4	13.0	61.6	21.9	100.0
Supervising student nurses.	n	0	2	23	97	24	146
	%	0.0	1.4	15.8	66.4	16.4	100.0
In-service training.	n	3	10	50	70	11	144
	%	2.1	6.9	34.7	48.6	7.6	100.0
Management of time.	n	1	5	30	75	34	145
	%	0 .7	3.4	20.7	51.7	23.4	100.0
Improvement of quality.	n	0	2	32	91	21	146
	%	0.0	1.4	21.9	62.3	14.4	100.0
Maintaining facilities, equipment and supplies.	n	3	5	24	96	18	146
	%	2.1	3.4	16.4	65.8	12.3	100.0

** Missing values varied between 1 and 6*

The knowledge of every individual in the organization has the potential power of contributing to the organization's goals and ensuring that the objectives of the organization are effectively executed (Shahabudin 2003:359).

As a follow-up on the question about knowledge and skills, respondents indicated (Table 4.4) the tasks they found the most difficult as those related to counselling (50; 34.0%), supervising students (35; 23.8%) and improving the quality of care (20; 13.6%). Not all professional nurses answered this question leading to the conclusion that those who did not answer this question did not find any tasks difficult. Respondents mentioned between 1 or 2 tasks each. This could be due to inexperience of professional nurses, insufficient guidance or lack of confidence (Swansburg & Swansburg 1999:22).

Table 4.4: Tasks found most difficult by professional nurses (n=147)

KNOWLEDGE AND SKILLS	**n**	**%**
Counselling of patients	50	34.0
Supervising students	35	23.8
Improving quality of care	20	13.6

4.3.2 Aspects related to performance appraisal

Measurement and evaluation of performance are very important tasks in any organization. It is a crucial part of an organization's improvement process and

contributes to assessing the employees' strengths, weaknesses and development needs (Troskie 1993:534; Torrington & Hall 1998:325).

The next section presents professional nurses' responses on performance review and appraisals.

4.3.2.1 Method of performance appraisal

Performance appraisal is not only considered to be an evaluation tool, but it is also an instrument for detecting shortcomings and skills gaps in work performance. It can also create corrective measures for those gaps.

The responses of professional nurses on how performance reviews are done in their hospitals are presented in Table 4.5.

In response to the question of how performance is reviewed in their ward, 56 (38.1%), of the professional nurses mentioned that performance is *not reviewed;* 34 (23.1%) said that *informal, but regular appraisal reviews* took place, while 28 (19.0%) said that informal, ad hoc reviews took place.

Table 4.5: Professional nurse responses on how performance appraisal is done (n=147)

PERFORMANCE REVIEW	n	%
A formal system of regular appraisals with reviews of past performance and setting of objectives.	23	15.6
Informal, but regular reviews involving discussions about past performance and agreed actions for the future.	34	23.1
Informal, *ad hoc* reviews, undertaken especially when there is a performance problem.	28	19.1
Not reviewed.	56	38.1
No response	6	4.1
TOTAL	**147**	**100.0**

It can be concluded that the formal performance appraisal system is not operational as substantiated by open-ended questions from three respondents who mentioned that what they would like to see changed is '*reinstatement of the performance appraisal'*. However, if it exists, as mentioned in Table 4.5, then one may conclude that the implementation of the performance appraisal system is not enforced, and appraisal depends on when and how the individual managers perform reviews.

This situation is very alarming, taking into account the crucial role of performance management in an organization (Armstrong 1994:25) and as indicated by Martinez (2003:216) that performance management is generally absent or limited in national health systems in developing countries. Though the situation is changing, there is a lot to be done to ensure that performance management of staff becomes a pivotal aspect of health service organizations.

More than a half (77; 52.2%) of the professional nurses said that the performance appraisal results are not used, while less than a third 26 (17.7%) and 21 (14.3%) said that the results are used for promotion and training, respectively (Table 4.6). These responses correlate with the responses in Table 4.5, with the majority mentioning that performance is not reviewed.

Table 4.6: Professional nurse responses on how performance appraisal results are utilised (n=147)

ASPECT	**n**	**%**
Training	21	14.3
Promotion	26	17.7
Demotion	4	2.7
Rotation	14	9.5
Not used	77	52.4
No response	5	3.4
TOTAL	**147**	**100.0**

4.3.2.2 Performance appraisal and utilisation

One of the purposes of performance appraisal is to enhance the productivity of an employee, by detection and elimination of problem areas in jobs or work environment (Troskie 1993:534; Price 2000:185).

Table 4.7 contains the responses of professional nurses on matters pertaining to performance appraisal and utilisation.

Although 58 (40.6%) of the respondents either *agreed* or *strongly agreed* that performance standards expected from staff are clear and understood, less

than a third (41; 28.5%) *strongly disagreed* and *disagreed* that objectives to be achieved are known by individuals to be assessed. According to Armstrong (1994:58) and Katz and Green (1997:91), performance standards are written statements that describe the level of performance as well as the satisfactory performance which the employee is expected to achieve; it is thus crucial that employees are aware of, and clearly understand the objectives to be achieved.

It is disconcerting that over three quarters (86; 61.0%) of the professional nurses responded either *strongly disagreed* or *disagreed* that constructive feedback on appraisal results is provided regularly, while over half (79; 55.3%) either *strongly disagreed* or *disagreed* that feedback on how staff was performing is provided on a regular basis throughout the year. Armstrong (1994:127), Jooste (1993a:269) and Rafferty et al (2005:30) confirm the importance of feedback on outcomes of performance appraisal as this is the means by which staff can be informed about their performance outcome.

It is noted that 69 (47.9%) of the professional nurses either *agreed* or *strongly agreed* that their managers or supervisors inspire them to do their best compared to 52 (36.2%) who either *strongly disagreed* or *disagreed* with the same statement.

Table 4.7: Professional nurse responses to performance appraisal and utilisation of results (n=147)

PERFORMANCE APPRAISAL AND UTILISATION	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
Objectives to be achieved are known by individuals to be assessed	n	22	19	43	46	14	144
	%	15.3	13.2	29.9	31.9	9.7	100.0
Performance standards expected from staff are clear and understood by all	n	20	26	39	38	20	143
	%	14.0	18.2	27.3	26.6	14.0	100.0
Constructive feedback on performance appraisal results is provided on a regular basis	n	49.0	37	23	25	7	141
	%	34.8	26.2	16.3	17.7	5.0	100.0
Feedback on how staff is performing is provided throughout the year	n	36.0	43	30	29	5	143
	%	25.2	30.1	21.0	20.3	3.5	100.0
Prompt action is taken when performance falls below acceptable standards	n	35	18	41	35	14	143
	%	24.5	12.6	28.7	24.5	9.8	100.0
My manager/supervisor inspires me to do my best	n	25	27	23	48	21	144
	%	17.4	18.8	16.0	33.3	14.6	100.0
Staff are given opportunity to make comments on the results of their performance	n	36	28	19	45	16	144
	%	25.0	19.4	13.2	31.3	11.1	100.0

* *Missing value varied between 3 and 6*

4.3.3 Aspects related to remuneration, benefits and recognition

Table 4.8 contains professional nurses' responses regarding aspects related to remuneration, benefits and recognition that may affect the performance of nurses. The majority of respondents were in disagreement with the following statements and either *strongly disagreed* or *disagreed*: that their remuneration is competitive with other organizations (69; 47.6%); that remuneration is in accordance with experience (72; 49.6%) and that remuneration is in accordance with their job responsibilities (75; 52.5%). Between 18 and 27 percent of respondents indicated uncertainty towards the above statements.

It can be concluded that some professional nurses were not happy with their remuneration; however, there are a significant number who do not feel the same. There may be a question as to whether these professional nurses are at all concerned about their remuneration package or whether they are just not well informed. The issue of low remuneration is substantiated by the responses to open-ended questions:

> "*I reach my maximum salary scale and remained at the scale for that last 5 years and I will remain at the scale for the next 20 years, unless there is an increment for all civil servants".*

> *"Remuneration does not compared well with other organizations, we are doing much more work than others, but are paid less".*

The above replies are supported by the literature which indicates that remuneration and incentives are seen as having a profound effect on the way

individuals are performing their jobs. Research has established that low remuneration is one of the factors contributing to de-motivation of health workers and eventually leads to migration of health workers from developing countries to developed countries (WHO 2003a:72; Martinez 2003:223). Contrary to the knowledge about remuneration aspects, it seems that respondents either *agreed* or *strongly agreed* that fringe benefits are known to them (55; 39.2%); however, a third (48; 34.2%) did not know the benefits, and 37 (26.2%) were uncertain.

Furthermore, over half of the respondents (77; 54.6%) *strongly disagreed* and *disagreed* that they are satisfied with their fringe benefits. Hicks and Adams (2003:267) mentioned the importance of benefits and incentives which have the potential for contributing to retaining the right number and mix of health personnel. This is substantiated by the responses from the open-ended questions:

> *"There is no other benefits, except for housing subsidy allowances"*
>
> *"The benefits are not clearly explained to us".*

With regard to the statement on recognition and career advancement, the majority (110; 75.9%) either *strongly disagree* or *disagree* that hardworking nurses were recognised, while less than half (67; 47.9%) either *strongly disagreed* or *disagreed* that opportunities existed for career advancement. This is substantiated by responses from open-ended questions:

“I am a registered nurse for 21 years and get the same salary as a person/registered with 5-10 years experience” and “Even if you study and have a degree you are just getting the same salary as the person who has only a general nursing diploma”

Table 4.8: Professional nurse responses on remuneration, benefits and recognition (n=147)

REMUNERATION, BENEFITS AND RECOGNITION	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
Your remuneration is competitive compared to other similar organizations.	n	39	30	40	32	4	145
	%	26.9	20.7	27.6	22.1	2.8	100.0
Remuneration is in accordance with your experience.	n	47	25	28	39	6	145
	%	32.4	17.2	19.3	26.9	4.1	100.0
Remuneration is in accordance with your job responsibility.	n	40	35	26	37	5	143
	%	28.0	24.5	18.2	25.9	3.5	100.0
Fringe benefits are known to you.	n	31	17	37	45	10	140
	%	22.1	12.1	26.4	32.1	7.1	100.0
You are satisfied with your fringe benefits.	n	44	33	37	24	3	141
	%	31.2	23.4	26.2	17.0	2.1	100.0
Opportunities exist for career advancement.	n	35	32	35	29	9	140
	%	25.0	22.9	25.0	20.7	6.4	100.0
Hardworking nurses are recognised.	n	70	40	21	8	6	145
	%	48.3	27.6	14.5	5.5	4.1	100.0

***Missing value varied between 2 and 7*.

4.3.4 Aspects related to staffing and work schedule

The questionnaire posed questions on issues pertaining to staffing and work schedule. Table 4.9 presents the responses in this regard.

Scheduling of staff is a task aimed at ensuring that staff are effectively assigned to nursing activities. With regard to overall work schedule, there were no major differences between opposing views. Almost half (63; 43.8%) responded either *strongly disagreed* and *disagreed* that the overall work schedule is fair; while a third (50; 34.7%) either *agreed* or *strongly agreed* that the work schedule is fair. Furthermore, more than a half (86; 59.3%) either *strongly disagreed* or *disagreed* that the allocated staff is sufficient to cover the current workload. Booyens (1996:246) stressed the importance of ensuring that staff assignments cover the wards adequately and at the same time satisfy staff duty preferences. The shortage of staff has been confirmed in the written responses by professional nurses. They mentioned some of the things they would like to see improved:

> *"Shortage of staff especially with a huge workload much more than the available staff". "Most nurses sometimes work beyond their scope of practice due to shortage of medical practitioners".*

> Shortages of staff may cause burn-out and stress-related illnesses that may affect the productivity of health workers. Therefore the Ministry of Health and Social Services commenced a workplace programme for care and counselling support for health workers. (McCourt & Awases 2005:17).

Table 4.9 Professional nurse responses on aspects of staffing and work schedule (n=147)

STAFFING AND WORK SCHEDULES	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
You get opportunities to make inputs into staffing policies and procedures.	n	68	31	23	21	2	145
	%	46.9	21.4	15.9	14.5	1.4	100.0
Opportunities exist for a flexible work schedule.	n	27	45	29	37	6	144
	%	18.8	31.3	20.1	25.7	4.2	100.0
The overall work schedule is fair.	n	25	38	31	47	3	144
	%	17.4	26.4	21.5	32.6	2.1	100.0
Overtime work is acceptable.	n	21	23	21	65	14	144
	%	14.6	16.0	14.6	45.1	9.7	100.0
There is a good balance between people who supervise work and people who do the work.	n	34	42	33	30	5	144
	%	23.6	29.2	22.9	20.8	3.5	100.0
The allocated staff in my unit is sufficient to cover the current workload.	n	44	42	25	25	9	145
	%	30.3	29.0	17.2	17.2	6.2	100.0
Care and support of staff in the form of counselling at the workplace is available.	n	63	30	26	21	5	145
	%	43.4	20.7	17.9	14.5	3.4	100.0

** Missing value varied between 2 and 3*

Table 4. 10: Professional nurse responses on staff development (n=147)

STAFF DEVELOPMENT	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
Opportunities for advancing in the organization exist.	n	31	35	41	29	8	144
	%	21.5	24.3	28.5	20.1	5.6	100.0
Good opportunities for continuous education are available.	n	32	29	36	40	8	145
	%	22.1	20.0	24.8	27.6	5.5	100.0
The necessary training is given to ensure job effectiveness.	n	17	22	54	46	6	145
	%	11.7	15.2	37.2	31.7	4.1	100.0
Job specific refresher courses are available.	n	37	30	37	31	4	139
	%	26.6	21.6	26.6	22.3	2.9	100.0
In-service training adequately addresses the skills gap.	n	17	34	47	41	6	145
	%	11.7	23.4	32.4	28.3	4.1	100.0
Incompetent nurses are identified and provided with the necessary support.	n	51	38	31	21	3	144
	%	35.4	26.4	21.5	14.6	2.1	100.0
Good leadership/management training available.	n	32	42	42	20	8	144
	%	22.2	29.2	29.2	13.9	5.6	100.0
Professional nurses participate in identifying their staff development needs.	n	30	29	31	40	15	145
	%	20.7	20.0	21.4	27.6	10.3	100.0

** Missing values varied between 2 and 8*

However, 93 (64.1%) of professional nurses respondents strongly disagreed or disagreed that care and support of staff exists in the form of counselling at the workplace. It can be concluded that not all nurses are aware of the programme and are therefore not utilising it.

4.3.5 Aspects related to staff development

Table 4.10 contains responses from professional nurses related to aspects of staff development. In determining staff development activities, responses were balanced between those who *disagreed* and those who *agreed*. Professional nurses either *strongly disagreed* or *disagreed* that opportunities for advancing in the organization exist (66; 45.8%), that good opportunities for continuous education are available (61; 44.1%). Others either *agreed* or *strongly agreed* that the necessary training is given to ensure job effectiveness (51; 35.8%) compared to others (39; 26.9) who either *strongly disagreed* or *disagreed* with the statement. According to Swansburg and Swansburg (1999:570), staff development programmes are planned and organised to aid staff in acquiring skills and knowledge which adds to job performance and at the same time increases their value as employees.

Other opposing views emerged on the issue that in-service training addresses the skills gap: almost a third (47; 32.4%) *either agreed* or *strongly disagreed*, while more than a third (51; 35.1%) either *strongly disagreed* or *disagreed* with the statement.

Table 4.11: Professional nurse responses on workspace and environment (n=147)

WORKSPACE AND ENVIRONMENT	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
My work environment is safe and free from hazards.	n	33	38	27	37	7	142
	%	23.2	26.8	19.0	26.1	4.9	100.0
Good workplace layout.	n	15	25	37	39	6	122
	%	12.3	20.5	30.3	32.0	4.9	100.0
Comfortable temperature.	n	23	35	28	50	9	145
	%	15.9	24.1	19.3	34.5	6.2	100.0
Necessary instruments are available.	n	38	43	14	41	5	141
	%	27.0	30.5	9.9	29.1	3.5	100.0
Instruments in working conditions.	n	38	43	16	41	5	143
	%	26.6	30.1	11.2	28.7	3.5	100.0
Materials and supplies sufficient.	n	40	49	19	29	7	144
	%	27.8	34.0	13.2	20.1	4.9	100.0
Antiseptic hand solution for protection of staff and patients is available.	n	17	23	14	71	19	144
	%	11.8	16.0	9.7	49.3	13.2	100.0
Infection control strategy guidelines available.	n	9	17	22	67	29	144
	%	6.3	11.8	15.3	46.5	20.1	100.0

** Missing value varied between 2 and 25*

4.3.6 Aspects related to workspace and environment

Workspace and environment include issues related to physical conditions such as work tools, equipment and material as well as physical layout such as space, and clean and safe environment. Table 4.11 presents professional nurses' responses with regard to workspace and environment.

The majority of respondents either *strongly disagreed* or *disagreed* that the necessary instruments are available (81; 57.5%), that instruments are in working condition (81; 56.7%) and that materials and supplies are sufficient (89; 61.8%). This was confirmed by the open-ended questions on what professional nurses want to see improved by mentioning issues such as "*maintaining of facilities and equipment", "modern equipment needed" and "speedy repair of equipment".*

However it is positive to note that more than half of the nurses either *agreed* or *strongly agreed* that infection control guidelines are available (96; 66.6%), and that antiseptic hand solutions for protection of staff and patients are available (90; 62.5%). It can be concluded that the opinion of professional nurses is that infection control is taken seriously and thus the patients and health workers are protected against transfer of infection. This is emphasised by Swansburg and Swansburg (1999:676) who stated that infection control is a major aspect of quality control and risk management. Contrary to this, half of the respondents (71; 50%) either *disagreed* or *strongly disagreed* that the work environment is safe and free from hazard.

4.3.7 Organizational processes

This section contains information about the opinion of professional nurses on the function and operations of the organization. Questions concerned issues such as mission and goals, commitment to the organization and personal satisfaction, reward and recognition, interpersonal relationships, management style, and the social and cultural factors that may affect the performance of professional nurses at the workplace.

4.3.7.1 Mission and goals

The mission statement of an organization is the highest priority in the organizational process. The mission is translated into specific goals and objectives for execution by various departments of the organization (Booyens & Minnaar 1996:40).

Table 4.12 consists of professional nurse responses on aspects related to the organization's mission and goals. Approximately half of professional nurses either *agree* or *strongly agreed* that the organization's mission is understood by everyone who works there (68; 46.3%), while 39 (26.5%) *neither agreed nor disagreed*. It can be assumed that all professional nurses are not well informed about the organizational mission and goals. This is alarming because, as mentioned by Schultz (2001:30), people who are aware of the mission and goals of an organization have strong identification with the organization, are committed and remain longer in the organization than those

who do not. More than half of the professional nurses either *agreed* or *strongly agreed* that they are clear about the objectives to be achieved (104; 70.8%) and that they know that their work contributes to the organization's mission (76; 51.7%). It is important for staff to be clear about the objectives of the organization. This is supported by Nickols (2003:2-3) and Fort and Voltero (2004:3) who mentioned that factors that are closely related to the level of performance include clear goals and objectives as well as intrinsic factors such as self perception, values and benefits.

Table 4.12: Professional nurse responses on organizational mission and goals (n=147)

MISSION AND GOALS	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
Most people here know how their work contributes to this organization's mission.	n	13	32	26	70	6	147
	%	8.8	21.8	17.7	47.6	4.1	100.0
This organization's mission is understood by everyone who works here.	n	11	29	39	57	11	147
	%	7.5	19.7	26.5	38.8	7.5	100.0
I am clear about the objectives I need to achieve.	n	5	7	31	83	21	147
	%	3.4	4.8	21.1	56.5	14.3	100.0
People in this organization have shared sense of purpose.	n	18	24	47	47	10	146
	%	12.3	16.4	32.2	32.2	6.8	100.0

** Missing value is 1*

Table 4.13: Professional nurse responses on reward and recognition (n=147)

REWARD/RECOGNITION	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
I receive prompt acknowledgement and recognition for doing a good job.	n	46	35	31	28	7	147
	%	31.3	23.8	21.1	19.0	4.8	100.0
I find my work rewarding.	n	31	22	31	45	14	143
	%	21.7	15.4	21.7	31.5	9.8	100.0
The work I do gives me a feeling of personal achievement.	n	11	6	14	91	25	147
	%	7.5	4.1	9.5	61.9	17.0	100.0
When I retire I will receive a reasonable pension from this organization.	n	15	12	56	51	13	147
	%	10.2	8.2	38.1	34.7	8.8	100.0
My pay is competitive with other, similar organizations.	n	23	51	47	24	2	147
	%	15.6	34.7	32.0	16.3	1.4	100.0

* *Missing value is 4*

4.3.7.2 Aspects related to personal reward and recognition

Table 4.13 consists of professional nurse responses regarding reward and recognition. The majority of respondents either *agreed* or *strongly agreed* that the work they are doing gives them a feeling of personal achievement (116; 78.9%) and that they found their work rewarding (59; 41.3%) while 31 (21.7%) were uncertain about this statement. This is substantiated by professional nurse responses to open-ended questions expressing their opinions about what they like about working for the organization:

> "*Provision of different health services needed by people"*
>
> *"Caring for sick helpless patients"*
>
> *"Teamwork - even though nurses are overworked and working under stressful situation, they are working as a team, they assist each other".*

These responses support the findings of Hicks and Adams (2003:260) regarding the link between internal rewards and motivation of work. Internal rewards include aspects such as self-actualisation, recognition and a sense of achievement, and are increasingly seen as important motivators. Contrary to the above, more than half (81; 55.1%) either *strongly disagreed* or *disagreed* that they received prompt acknowledgement and recognition for doing a good job, while half (74; 50.3%) either *strongly disagreed* or *disagreed* that their pay is competitive with other similar organizations. Less than half (64; 43.5%) either *agreed* or *strongly agreed* that when they retire they will receive a reasonable pension from the organization, while 56 (38.1%) *neither agreed nor disagreed* with the statement.

Table 4.14: Professional nurse responses on commitment and satisfaction (n=147)

COMMITMENT AND SATISFACTION	**AGREEMENT (ON A SCALE OF 1 TO 5)**						**TOTAL***
		STRONGLY DISAGREE	**DISAGREE**	**NEITHER AGREE NOR DISAGREE**	**AGREE**	**STRONGLY AGREE**	
I am proud to tell people that I work for this organization.	n	15	12	23	62	34	146
	%	10.3	8.2	15.8	42.5	23.3	100.0
I do not like the way this organization operates.	n	8	37	49	38	15	147
	%	5.4	25.2	33.3	25.9	10.2	100.0
This organization provides me with skills and knowledge that will benefit my future career.	n	13	14	37	71	12	147
	%	8.8	9.5	25.2	48.3	8.2	100.0
Doing this job makes me feel good about myself.	n	8	7	16	75	39	145
	%	5.5	4.8	11.0	51.7	26.9	100.0
I am subject to personal criticism or abuse at work.	n	24	50	32	27	9	142
	%	16.9	35.2	22.5	19.0	6.3	100.0
I am constantly seeking out new challenges at work.	n	4	16	32	71	19	142
	%	2.8	11.3	22.5	50.0	13.4	100.0

** Missing value varied between 1and 5*

4.3.7.3 Aspects related to commitment and satisfaction

Table 4.14 presents responses from professional nurses with regard to personal commitment and satisfaction with their work.

There seems to be a sense of professional pride and a sense of vocation as indicated by the following responses when respondents either *agreed* or *strongly agreed* that doing this job makes them feel good about themselves (114; 78.6%), that they are proud to tell people that they work for this organization (96; 65.8%), that the organization provides them with skills and knowledge that will benefit their future (83; 56.5%).

It can be concluded that professional nurses are committed and satisfied; they feel that there are future advantages in working as nurses for the organization. This can be attributed perhaps to the values and norms of the organization and not only to external rewards such as remuneration (McNeese-Smith & van Servellen 2000:98).

Table 4.15: Professional nurse responses on management style (n=147)

MANAGEMENT	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
My manager/supervisor inspires me to do my best.	n	24	13	32	62	16	147
	%	16.3	8.8	21.8	42.2	10.9	100.0
When changes are made in the way things are done, management always first informs the people who will be affected.	n	20	30	43	47	7	147
	%	13.6	20.4	29.3	32.0	4.8	100.0
If I have an idea for improving the way we do our work, my supervisor/manager will usually listen to me.	n	14	19	56	52	6	147
	%	9.5	12.9	38.1	35.4	4.1	100.0
My manager/supervisor gives me regular, timely feedback that helps me improve my performance.	n	23	31	46	38	9	147
	%	15.6	21.1	31.3	25.9	6.1	100.0
I am afraid to openly express my ideas and opinions.	n	32	50	24	30	11	147
	%	21.8	34.0	16.3	20.4	7.5	100.0
Senior managers in this organization are open to new ideas and suggestions.	n	27	34	41	39	6	147
	%	18.4	23.1	27.9	26.5	4.1	100.0
I trust and respect my immediate supervisor.	n	3	1	24	92	27	147
	%	2.0	0.7	16.3	62.6	18.4	100.0

4.3.7.4 Aspects related to management style

Generally and historically, nursing is considered as a caring profession that requires professional nurses to deal with issues of human behaviour both for the patient and the nurses working under supervision.

Table 4.15 consists of professional nurse responses on aspects related to management style.

In response to a question on management, the majority, either *agreed* or *strongly agreed* with the statements that they trust and respect their immediate supervisor (119; 81.0%) and that their manager or supervisor inspires them to do their best (78; 53.1%). Over a third (54; 36.8%) either *agreed* or *strongly agreed* that when changes are made in the way things are done, management always informs the people who will be affected, while 43 (29.3%) *neither disagreed nor agreed* with this statement.

Less than a third (54:36.7%) strongly disagreed or disagreed that their manager/supervisor gives them regular, timely feedback that helps them improve their performance, while just less than a third (46:31.6%) neither agree or disagree with the statement. Less than half (61:41.5%) strongly disagreed or disagreed that senior managers in their organization are open to new ideas and suggestions, while less that a third (41:30.6%) either agreed or strongly disagreed with the statement.

It can be deduced that professional nurses have the highest regard and respect for their supervisors and that they feel motivated to perform, however it seems as their participation in decision-making was limited. It can therefore be concluded that both the autocratic and democratic management style is employed. According to Jooste (1996b:171) no one single style could be applied in all situations in nursing, but the style employed will differ according to the situation at hand.

4.3.7.5 Aspects related to performance

In an attempt to ascertain the opinion of professional nurses with regard to performance, several statements were posed to verify respondents' views. Table 4.16 presents the responses of the professional nurses in relation to issues related to performance.

Although the majority (125; 85.1%) of respondents either *agreed* or *strongly agreed* that their work contributes to the organization's performance, the rest of the responses were negative. For instance half (73; 49.6%) of the professional nurses either *agreed* or *strongly agreed* that they are given enough authority to allow them to do their job effectively, while one third (49; 33.3%) *neither disagreed nor agreed*. About half (62; 42.2%) either *strongly disagreed* or *disagreed* that judgements about their performance are fair, while nearly a third (43; 29.3%) *neither disagreed nor agreed*.

Table 4.16: Professional nurse responses on performance (n=147)

PERFORMANCE	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
My performance is judged more by how much work I do than by how well I do it.	n	8	30	39	43	24	144
	%	5.6	20.8	27.1	29.9	16.7	100.0
My manager emphasises my positive contributions when reviewing my performance.	n	25	16	39	59	8	147
	%	17.0	10.9	26.5	40.1	5.4	100.0
I am given enough authority to allow me to do my job effectively.	n	9	16	49	59	14	147
	%	6.1	10.9	33.3	40.1	9.5	100.0
People in this organization put more energy into identifying mistakes than into figuring out how to do things right.	n	13	13	35	45	41	147
	%	8.8	8.8	23.8	30.6	27.9	100.0
Judgement about my performance is fair.	n	19	23	43	53	9	147
	%	12.9	15.6	29.3	36.1	6.1	100.0
The way things are organised around here makes it hard for people to do their best work.	n	5	37	35	46	22	145
	%	3.4	25.5	24.1	31.7	15.2	100.0
I feel my work contributes to the organization's performance.	n	0	7	15	82	43	147
	%	0.0	4.8	10.2	55.8	29.3	100.0

** Missing value is between 2 and 3*

It is noted that 68 (46.9%) either *agreed* or *strongly agreed* that the way things are organised makes it hard for people to do their best, while 35 (24.1%) *neither agreed nor disagreed*. It can be concluded that performance management systems that are in place do not allow for participation or give some authority to subordinates to make decisions on their work (Martinez 2003:226).

4.3.7.6 Aspects related to interpersonal relations

Interpersonal relations, including communication and teamwork, is one of the main aspects of an organization (Jooste 1993a:270). Table 4.17 presents responses of nurse managers on issues associated with interpersonal relations.

More than half of the professional nurses were in support of the following statements by responding either *agreed* or *strongly agreed*: colleagues value their contributions (92; 62.6%); they are working with skilled competent people who are good at their jobs (100; 68.0%); people from different departments or programmes try to help each other (77; 52.4%); people they work with are comfortable with suggestions to change the organization (78; 53.1%); there is a great deal of cooperation between people in the organization (69; 47.0%). It can be deduced that working relations and climate contribute to teamwork which itself is a motivator for high productivity and job satisfaction, and subsequently will contribute to improved performance (Adams & Bond 2000:538).

Table: 4.17: Professional nurse responses on interpersonal relations (n=147)

INTERPERSONAL RELATIONS	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
In this organization, people in different departments or programmes try to help each other.	n	8	18	44	62	15	147
	%	5.4	12.2	29.9	42.2	10.2	100.0
I work with skilled competent people who are good at their jobs.	n	2	16	29	80	20	147
	%	1.4	10.9	19.7	54.4	13.6	100.0
The people I work with are comfortable in suggesting changes and improvements to each other.	n	18	17	34	63	15	147
	%	12.2	11.6	23.1	42.9	10.2	100.0
There is a great deal of cooperation between people in this organization.	n	8	12	58	57	12	147
	%	5.4	8.2	39.5	38.8	8.2	100.0
My colleagues value my contribution.	n	5	15	35	82	10	147
	%	3.4	10.2	23.8	55.8	6.8	100.0
I am not included in hospital/ward activities or made to feel part of the team.	n	26	69	24	18	6	143
	%	18.2	48.3	16.8	12.6	4.2	100.0

** Missing value is 4*

This is supported by responses from professional nurses when asked what they like about working for their organization:

> "*Teamwork that gives opportunity for us to know ourselves and the job as well as to get knowledge of the community".*
> *"My supervisors are listening to my personal problems for example changing of duties".*
> "*One gets opportunities to express oneself; one gets an opportunity to run the ward to the best of her or his ability without being disturbed by seniors".*

4.3.7.7 Aspects related to social and cultural aspects

Table 4.18 presents responses from professional nurses on issues related to social and cultural aspects. Less than half of the respondents (70: 48.3%) either *agreed* or *strongly agreed* that the community they lived in has the highest regard for their organization, while 41(28.3%) *neither agreed nor disagreed* with the statement.

Notwithstanding that the majority 60 (41.7%) of the professional nurses either *strongly disagreed* or *disagreed* that some cultural beliefs of the community they are living in are in conflict with some of the organizations policies, however, over a third (56: 38.9%) either *agreed* or *strongly agreed* with the statement while 28 (19.4%) *neither agreed nor disagreed* with the statement. This can be concluded that cultural believes and values in the larger society may influence to some extend performance behaviour at the workplace (Franco & Bennet 1999:19)

Table 4 .18: Professional nurse responses on aspects related to social and cultural factors (n=147)

SOCIAL AND CULTURAL BELIEFS AND FACTORS	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
Some cultural beliefs in the community I am living are in conflict with some my organization policies.	n	19	41	28	39	17	144
	%	13.2	28.5	19.4	27.1	11.8	100.0
The community I live in has the highest regards for my organization	n	7	27	41	49	21	145
	%	4.8	18.6	28.3	33.8	14.5	100.0

** Missing value varied between 2 and 3*

4.3.8 Open-ended questions

In order to capture spontaneous responses, open-ended questions asked professional nurses about aspects related to *what they like most working for their organization*, *what they like least working for the organization* and *what they would like to see changed or improved*. Professional nurses provided more than one response per question; however, not all respondents provided a response to all open-ended questions. Responses were clustered according to issues which were frequently mentioned by respondents.

4.3.8.1 Aspects that professional nurses like most or least about working for their organization

Table 4.19 presents the common responses from professional nurses on issues they like about working for their organization.

Table 4. 19: Professional nurse responses about what they like most about working for their organization (n=147)

ISSUE	n	%
Caring for sick helpless patients	60	40.8
Good cooperation and teamwork among staff members	25	17.0
Opportunities for skills development	20	13.6
Guiding and teaching students	25	17.0
Relatively acceptable benefits	20	13.6
Personal achievement	15	10.2
Overtime hours and pay	10	6.8
Health education to patients	20	13.6

Caring for sick and helpless patients was mentioned by the majority (60; 40.8%) of the respondents which supports the notion that nursing is a caring profession. This is supported by literature that suggests that nurses' primary professional responsibility is to provide care and support to those who require nursing (WHO 2002c:12).

Table 4.20 presents the common responses from professional nurses on issues they like least.

Table 4.20: Professional nurse responses about what they like least about working for their organization (n=147)

ISSUE	n	%
Insufficient materials and supplies	20	13.6
Non-acknowledgement and recognition of nurses' contributions	15	10.2
Salaries of nurses	15	10.2
Bureaucratic way of running the organization	10	10.2
Underpaid, but big workload	30	20.4
Shortage of staff	40	27.2
Lack of management skills (planning and organising of nursing services)	10	10.2
Lack of nursing standards	20	13.6

Professional nurses identified issues which they do not like in the organization; these included shortage of staff, mentioned by 40 (27.2%) followed by being underpaid despite having a heavy workload (30; 20.4%); 15 (10.2%) are dissatisfied with their salary. This correlates well with the

responses provided in Table 4.8 indicating that remuneration is not in accordance with job responsibility (75; 52.5%). In addition to the responses provided in Table 4.20, other specific individual responses were given about what professional nurses did not like in the organization:

"Weekly meetings that are only attended by unit managers without input from other staff members".

"Duplication of recordkeeping, resulting in more writing time, less time for patient care".

"Bureaucratic system makes it impossible to develop new ideas".

4.3.8.2 Aspects which need to be improved or changed

Table 4.21 presents the common responses from professional nurses on what they would like to see changed or improved.

Table 4.21: Professional nurse responses about what they would like to see improved or changed in their organization (n=147)

ISSUE	n	%
More training at clinical level	40	27.2
Competitive salaries for personnel at ward level	30	20.4
Sufficient maintenance of equipment and materials	36	24.4
Skills and knowledge development programmes to be enforced	20	13.4
Introduce nursing care quality improvement programme	47	31.9
Care and support through counselling	20	13.4
Better nurse/manager rotation system to be introduce	20	13.4
Reward, incentives and recognition to those who are performing	26	17.6
Career advancement and promotion of staff to be reviewed	44	29.9
Introduce fixed overtime for nurses	30	20.4

Professional nurses provided rich in-depth information on suggestions about what they would like to see changed or improved. Those issues which the nurses felt needed to be improved are: introducing nursing quality improvement programmes (47; 31.7%); career advancement, including promotion (44; 29.9%); and training at ward level (40; 27%). Equally important were improved competitive salaries (30; 20.4%), sufficient materials and supplies (36; 24.4%), as well as fixed overtime (30; 20.4%). Some other important individual responses on what needed to change or improve include:

"Autocratic type of leadership practices to be changed".

"Managers to be role models".

"I would like to see changing of nurses' attitudes towards the patients and colleagues".

"Reinstatement of performance appraisal".

"To improve and renovate the nurses' accommodation (nurses' home) which is currently in a deplorable state".

"Shortages of medical doctors".

"Clinical instructors should be employed to be involved in clinical practice of student nurses, because they consume much of the time of professional nurses (shortage of staff). This allows better guidance of student"'.

4.4 RESULTS OF QUESTIONNAIRE 2

The statistical information presented in this section is from 42 questionnaires received from nurse managers. Much of the information requested from professional nurses in questionnaire 1 was also required from nurse managers. This was done to compare some important views and responses with those expressed by professional nurses.

The background information and substantiation from the content of questions came from the same sources for both questionnaires. Therefore, this section does not give background but concentrates on the data procured. Literature sources have been used in the discussion of the first group and will thus not be repeated in the discussion of questionnaires. Substantiation or contradiction of results will only be done where it differs from what is discussed in questionnaire 1.

Questionnaire 2 included questions that focused on management skills and leadership. These questions were not included in questionnaire 1 and will therefore be discussed in more detail.

This section presents results derived from questionnaire 2 completed by nurse managers. It is guided by the respective aims and objectives of the study as indicated in Section 3.2 of Chapter 3.

4.4.1 Aspects related to nurse managers' management skills

Management is the act of coordinating work activities through people to ensure that the work done is efficiently and effectively completed (Koch 1996:98).

Table 4.22 presents responses with regard to nurse managers' experience and involvement in executing the management functions.

It is clear that the majority of nurse managers have been involved in executing management functions as indicated by the *Yes* responses on their experience involving: orientation of new staff (38; 90,5%); managing conflict (35; 83.3%); providing training to employees (33; 78.6%) and counselling (29; 69.0%). Although the majority said *Yes* for being involved in the abovementioned skills, quite a noteworthy number responded *No* to training employees (9; 21.4%) or placement of staff according to skills (11; 26.2%).

Monitoring performance is an important function of the manager, and interviews on outcome performance with subordinates is essential (Price 2000:203; Jooste 1993a:269; Armstrong 1994:124; Rafferty et al 2005:30). It is however alarming to see that more than half (22; 61.1%) of the nurse managers were not involved in one-to-one performance appraisal interviews related to performance outcome of their subordinates. Over half (22; 52.4%) indicated no involvement in operational research. It is alarming that nearly half of the nurse managers were not involved in operational research. It can be

Table 4.22: Nurse managers' experiences in dealing with specific situations related to management functions (n=42)

MANAGEMENT FUNCTION		NO	YES	TOTAL*
Providing training to employees.	n	9	33	42
	%	21.4	78.6	100.0
One-to-one performance interview related to performance outcome.	n	22	14	36
	%	61.1	38.9	100.0
Placement of staff according to skills.	n	11	31	42
	%	26.2	73.8	100.0
Orientation of new staff.	n	4	38	42
	%	9.5	90.5	100.0
Managing conflict.	n	7	35	42
	%	16.7	83.3	100.0
Operational research.	n	22	20	42
	%	52.4	47.6	100.0
Counselling of employees.	n	13	29	42
	%	31.0	69.0	100.0

* *Value of missing response is 6*

assumed that due to insufficient involvement they are not experienced or comfortable in initiating nursing research on they own. This is supported by Volmink and Dare (2005:705) who mentioned that developing countries are scientifically lagging behind developed countries with regard to research capacity, including investment and sufficiently skilled people to conduct research.

Table 4.23: Nurse managers' responses on tasks they found the most difficult (n=42).

TASKS	**n**	**%**
Managing conflict	12	28.5
Operational research	10	23.6
Counselling of employees	16	38.0

Although nurse managers were involved in numerous tasks, they mentioned quite a number which they found difficult. Those listed in Table 4.23 were mentioned frequently as being the most difficult: counselling of employees (16; 38.0%), managing conflict (12; 28.5%) and operational research (10; 23.6%). It can be assumed that some nurses are having difficulty in executing these management functions due to insufficient skills or are not prepared or experienced enough to operate at management level dealing with the mentioned issues (Awases et al 2004:58).

4.4.2 Management and related training

In an attempt to determine the knowledge base of the respondents, it was deemed necessary to determine whether they had any appropriate management training. Table 4.24 presents responses about management training received.

Two thirds nurse of managers (27; 64.3%) indicated that they have received management training or related training, while over a third (15; 35.7%) indicated that they have not received any management or related training. It is thus evident that nearly a third of nurse managers has not received any additional management training and therefore has no training in management concepts, theories and skills that should empower them to perform management functions. Swansburg and Swansburg (1999:38) stressed the importance of updating the management skills to be able to manage in the new evolving health environment.

Table 4.24: Percentage of nurse managers who received management training (n=42)

MANAGEMENT AND RELATED TRAINING RECEIVED	n	%
Training received	27	64.3
No training received	15	35.7
TOTAL	42	100.0

4.4.3 Aspects related to adequacy of training

The extent to which respondents consider management training to be adequate is reflected in Table 4.25.

Less than a third of the nurse managers (8; 29.6%) felt that their training was sufficient *to some degree*; half of them (14; 51.9%) stated that the training they received was sufficient *to a large degree*, while four (14.8%) confirmed that their training was sufficient *to a very large degree*. It is noted that only one (3.7%) of the respondents considered their management training as *not sufficient at all*. This confirms the availability of different courses; however, it seems that the content and intensity of the courses vary.

Table 4.25: Nurse managers' responses on adequacy of management training received (n=27)

ADEQUACY OF TRAINING	n	%
Not at all	1	3.7
To some degree	8	29.6
To a large degree	14	51.9
To a very large degree	4	14.8
Total	27	100.0

Table 4.26: Nurse managers' responses on their knowledge and skills (n=42)

RATING OF KNOWLEDGE AND SKILLS		VERY POOR	POOR	AVERAGE	GOOD	EXCELLENT	TOTAL
Nursing service policy implementation.	n	0	1	19	19	2	41
	%	0.0	2.4	46.3	46.3	4.9	100.0
Planning nursing service delivery.	n	0	5	16	17	3	41
	%	0.0	12.2	39.0	41.5	7.3	100.0
Nursing audit.	n	3	4	16	12	6	41
	%	7.3	9.8	39.0	29.3	14.6	100.0
Development of nursing performance standards.	n	4	6	19	11	1	41
	%	9.8	14.6	46.3	26.8	2.4	100.0
Development of competencies.	n	3	3	19	12	3	40
	%	7.5	7.5	47.5	30.0	7.5	100.0
Skills development.	n	1	5	13	16	5	40
	%	2.5	12.5	32.5	40.0	12.5	100.0
Interpersonal relations.	n	1	4	6	20	9	40
	%	2.5	10.0	15.0	50.0	22.5	100.0
Counselling skills.	n	2	5	17	15	2	41
	%	4.9	12.2	41.5	36.6	4.9	100.0
Performance appraisal of subordinates.	n	5	5	13	12	5	40
	%	12.5	12.5	32.5	30.0	12.5	100.0
Supportive supervision.	n	2	4	9	22	3	40
	%	5.0	10.0	22.5	55.0	7.5	100.0
Problem solving.	n	1	0	9	23	8	41
	%	2.4	0.0	22.0	56.1	19.5	100.0
Motivation of staff.	n	2	0	15	19	5	41
	%	4.9	0.0	36.6	46.3	12.2	100.0
Organising facilities, equipment and supplies.	n	3	6	11	17	4	41
	%	7.3	14.6	26.8	41.5	9.8	100.0

**Missing value varied between 1 and 2*

4.4.4 *Aspects related to nurse managers' knowledge and skills in managing clinical wards*

A manager has the responsibility to achieve the organizational goals by facilitating, directing and enabling people in the organization. It is therefore expected that a manager possess skills for planning, organising, leading and controlling (Daft & Noe 2001:20).

Table 4.26 presents nurse managers' responses on their knowledge and skills in managing human resources in the wards. For the sake of discussion, the values attributed to *very poor* and *poor* were grouped together and considered unsatisfactory, whereas the *good* and *excellent* values combined were noted as satisfactory.

There was a modest difference between satisfactory and average rating of nurse manager skills for the following: Just more than half (21; 51.2%) rated themselves as satisfactory on implementation of nursing service policy, while nearly half (19; 46.3%) said their skills were average. Furthermore, nearly half rated their skills as satisfactory in planning for nursing service delivery (20; 48.8%) and nursing audit (18; 43.9%) while just over a third rated themselves as average (16; 39%) in these two areas.

Less than half of the nurse managers (17; 42.5%) felt their skills on performance appraisal of subordinates are satisfactory, while a third (13;

32.5%) rated themselves as average. It appears that not all nurse managers' management skills are adequate. For instance, approximately half of the nurse managers (19; 46.3%) rated their skills as average for developing nursing performance standards, while less than a third (10; 24.4%) felt their skills were unsatisfactory. It can be concluded that although the nurse managers rated most of their skills as satisfactory, there are some who lack crucial management skills. This can be attributed to the fact that a third (15; 35.7%) did not receive any management or related training (Table 4.23) or because only five (11.9%) indicated that they received training at Master's level (Figure 4.5).

4.4.5 Aspects related to performance

The importance of performance monitoring and evaluation as a crucial part of the organization's operations has been echoed by many authors (Troskie 1993:534; Katz & Green 1997:27; Torrington & Hall 1998:325; Winch et al 2003:10).

4.4.5.1 Methods of performance appraisal

Table 4.27 presents nurse manager responses on how performance appraisal is conducted.

It is distressing to note that nearly half of the nurse managers (15; 41.7%) stated that performance is *not reviewed*, while 12 (33.3%) stated that *informal, ad hoc appraisals* were done.

Table 4.27: Nurse managers' responses on how performance appraisal is conducted (n=42)

PERFORMANCE REVIEW	n	%
A formal system of regular appraisals with reviews of past performance and setting of objectives.	8	22.2
Informal, but regular reviews involving discussions about past performance and agreed actions for the future.	1	2.8
Informal, *ad hoc* reviews, undertaken especially when there is a performance problem.	12	33.3
Not reviewed.	15	41.7
No answer	6	4.8
TOTAL	42	100.0

These responses are consistent with responses provided by professional nurses as indicated in Table 4.5 where over a third of the professional nurses (56; 39.7%) said that performance was *not reviewed*, and that *informal, ad hoc* reviews were undertaken especially when there is a performance problem.

Table 4.28: Nurse managers' responses on performance appraisal (n=42)

PERFORMANCE APPRAISAL AND UTILISATION	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
Objectives to be achieved are known by individuals to be assessed.	n	6	7	8	14	5	40
	%	15.0	17.5	20.0	35.0	12.5	100.0
One-to-one performance interview on the outcome of performance appraisal is conducted.	n	7	10	12	6	3	38
	%	18.4	26.3	31.6	15.8	7.9	100.0
Performance standards expected from staff are clear and understood by all.	n	7	10	10	9	4	40
	%	17.5	25.0	25.0	22.5	10.0	100.0
Peer review of performance is done.	n	13	12	7	6	0	38
	%	34.2	31.6	18.4	15.8	0.0	100.0
Constructive feedback on performance appraisal results is provided on a regular basis.	n	10	15	6	7	1	39
	%	25.6	38.5	15.4	17.9	2.6	100.0
Feedback of how staff is performing is provided throughout the year.	n	10	13	3	10	4	40
	%	25.0	32.5	7.5	25.0	10.0	100.0
Prompt action is taken when performance falls below acceptable standards.	n	6	11	10	6	6	39
	%	15.4	28.2	25.6	15.4	15.4	100.0
My manager/supervisor inspires me to do my best.	n	3	6	9	16	6	40
	%	7.5	15.0	22.5	40.0	15.0	100.0
Staff are given opportunity to make comments on the results of their performance.	n	7	13	9	6	4	39
	%	17.9	33.3	23.1	15.4	10.3	100.0
Self assessment by employees to review their own performance is done.	n	13	13	3	5	4	38
	%	34.2	34.2	7.9	13.2	10.5	100.0

** Missing response varied between 2 and 4*

4.4.5.2 Performance appraisal and utilisation

Table 4.28 presents the responses of nurse managers regarding performance appraisal and utilisation.

Less than half of the nurse managers either *agreed* or *strongly agreed* that the objectives to be achieved are known by the individuals to be assessed (19; 47.5%); while 17 (42.5%) either *strongly disagreed* or *disagreed* that performance standards expected from staff are clear and understood.

Furthermore, nurse managers *strongly disagreed* or *disagreed* that one-to-one performance interviews on the outcome of performance appraisal is conducted (17; 44.7%); that feedback of how staff is performing is provided throughout the year (23; 57.5%); that constructive feedback on performance appraisal results is provided on a regular basis (25; 64.1%); that self assessment by employees to review their own performance is done (26; 68.4%) and that staff are given an opportunity to make comments on the results of their performance (20; 51.2%).

Table 4.29: Nurse managers' responses on remuneration, benefits and recognition (n=42)

REMUNERATION, BENEFITS AND RECOGNITION	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
Your remuneration is competitive compared to other similar organizations.	n	12	10	7	9	3	41
	%	29.3	24.4	17.1	22.0	7.3	100.0
Remuneration is in accordance with your experience.	n	14	12	2	12	1	41
	%	34.1	29.3	4.9	29.3	2.4	100.0
Remuneration is in accordance with your job responsibility.	n	14	13	1	11	2	41
	%	34.1	31.7	2.4	26.8	4.9	100.0
Fringe benefits are known to you.	n	7	9	9	12	4	41
	%	17.1	22.0	22.0	29.3	9.8	100.0
You are satisfied with your fringe benefits.	n	13	9	6	8	4	40
	%	32.5	22.5	15.0	20.0	10.0	100.0
Opportunities exist for career advancement.	n	10	8	9	10	4	41
	%	24.4	19.5	22.0	24.4	9.8	100.0
Hardworking nurses are recognised.	n	17	7	5	6	7	42
	%	40.5	16.7	11.9	14.3	16.7	100.0

***Missing value varied between 1 and 2*

4.4.6 Aspects related to remuneration, benefits and recognition

More than half of the nurse managers responded to statements listed in Table 4.29 by either *strongly disagreeing* or *disagreeing* that remuneration is competitive compared to other similar organizations (22; 53.7%); that remuneration is according to one's experience (26; 63.4%); that they are satisfied with their fringe benefits (22; 55.0%). Furthermore, they either *strongly disagreed* or *disagreed* that opportunities exist for career advancement (18; 43.9%) and that hardworking nurses are recognised (24; 57.2%). This is substantiated by the responses from open-ended questions:

> *"Remuneration is not in accordance with the job I am doing, because I am a supervisor with a remuneration of a junior registered nurse".*

> *"Subordinates are better paid then nurse managers, especially when it comes to Sundays, public holidays and overtime".*

4.4.7 Aspects related to staffing and work schedules

Table 4.30 presents the responses of the nurse managers on issues regarding staffing and work schedules.

Over half of the nurse managers *agreed* or *strongly agreed* with the following statements: that overall work schedule is fair (22; 52.5%); that opportunities

exist for flexible work schedule (19; 45.3%) and that overtime is acceptable (24; 57.1%). However, quite a number of respondents either *strongly disagreed* or *disagreed* that the staff assigned to their units are sufficient to cover the current workload (24; 57.2%); that they have opportunities to make input in staffing policies and procedures (21; 50.0%); and that care and support of staff in the form of counselling at work is available (20; 48.8%).

4.4.8 Aspects related to staff development

Responses of nurse managers on matters related to staff development are recorded in Table 4.31.

Half of the nurse managers *strongly disagreed* or *disagreed* that opportunities for continuous education exist (21; 50%) and that good leadership and management training are available (17; 41.5%). However, almost half of the respondents *agreed* or *strongly agreed* that opportunities for advancing in the organization exist (18; 42.8%); that in-service training adequately addresses the skills gap (22; 53.6%); that job-specific refresher courses are available (18; 42.9%); and that necessary training is given to ensure job effectiveness (17; 40.5%).

Table 4.30: Nurse managers' responses on aspects of staffing and work schedules (n = 42)

STAFFING AND WORK SCHEDULES	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
You get opportunities to make inputs into staffing policies and procedures.	n	16	5	6	11	4	42
	%	38.1	11.9	14.3	26.2	9.5	100.0
Opportunities exist for a flexible work schedule.	n	4	7	12	12	7	42
	%	9.5	16.7	28.6	28.6	16.7	100.0
The overall work schedule is fair.	n	4	7	9	16	6	42
	%	9.5	16.7	21.4	38.1	14.3	100.0
Overtime work is acceptable.	n	7	6	5	16	8	42
	%	16.7	14.3	11.9	38.1	19.0	100.0
There is a good balance between people who supervise work and people who do the work.	n	9	8	10	10	5	42
	%	21.4	19.0	23.8	23.8	11.9	100.0
The allocated staff in my unit are sufficient to cover the current workload.	n	13	11	3	9	6	42
	%	31.0	26.2	7.1	21.4	14.3	100.0
Care and support of staff in the form of counselling at the workplace is available.	n	11	9	5	9	7	41
	%	26.8	22.0	12.2	22.0	17.1	100.0

**Missing value is 1*

Table 4.31: Nurse managers' responses on staff development (n =42)

STAFF DEVELOPMENT	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
Opportunities for advancing in the organization exist.	n	4	9	11	15	3	42
	%	9.5	21.4	26.2	35.7	7.1	100.0
Good opportunities for continuous education are available.	n	7	14	6	11	4	42
	%	16.7	33.3	14.3	26.2	9.5	100.0
The necessary training is given to ensure job effectiveness.	n	7	6	12	13	4	42
	%	16.7	14.3	28.6	31.0	9.5	100.0
Job-specific refresher courses are available.	n	8	6	10	16	2	42
	%	19.0	14.3	23.8	38.1	4.8	100.0
In-service training adequately addresses the skills gap.	n	3	11	5	19	3	41
	%	7.3	26.8	12.2	46.3	7.3	100.0
Incompetent nurses are identified and provided with necessary support.	n	11	9	8	10	4	42
	%	26.2	21.4	19.0	23.8	9.5	100.0
Good leadership/management training is available.	n	8	9	13	11	0	41
	%	19.5	22.0	31.7	26.8	0.0	100.0
Professional nurses participate in identifying their staff development needs.	n	2	9	12	14	5	42
	%	4.8	21.4	28.6	33.3	11.9	100.0

* *Missing value is 1*

4.4.9 Aspects related to workspace and environment

Table 4.32 contains responses related to workspace and environment. Views on workspace and environment were balanced, with more or less the same number of respondents providing positive or negative responses on the same statement. They either *strongly disagree* or *disagree*: that the work environment is safe and free of hazards (20; 48.8%), while 17 (41.5%) *agree* or *strongly agree* with the statement. Furthermore, respondents stated that they *strongly disagree* or *disagree* that the necessary instruments are available (23; 56.1%); that equipment is in working condition (20; 48.8%); that materials and supplies are sufficient (28; 68.3%). More than half the respondents either *agree* or *strongly agree* that infection control strategy guidelines were available (32; 78.0%) and that antiseptic solutions for protection of staff and patients are available (23; 56.1%).

4.4.10 Aspects related to leadership and management

Table 4.33 listed variables that are applicable to leadership and management philosophy and the responses of the nurse managers as indicated. For the sake of the discussion, the percentages of the positive values (*tend to agree* and *fully agree)* were combined.

Table 4.32: Nurse managers' responses on workspace and environment (n=42)

WORKSPACE AND ENVIRONMENT	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE	
My work environment is safe and free from hazards.	n	7	13	4	13	4	41
	%	17.1	31.7	9.8	31.7	9.8	100.0
Good workplace layout.	n	7	10	10	10	4	41
	%	17.1	24.4	24.4	24.4	9.8	100.0
Comfortable temperature.	n	8	6	10	13	4	41
	%	19.5	14.6	24.4	31.7	9.8	100.0
Necessary instruments are available.	n	14	9	3	11	4	41
	%	34.1	22.0	7.3	26.8	9.8	100.0
Instruments in working conditions.	n	10	10	7	10	4	41
	%	24.4	24.4	17.1	24.4	9.8	100.0
Materials and supplies sufficient.	n	13	15	3	6	4	41
	%	31.7	36.6	7.3	14.6	9.8	100.0
Antiseptic hand solution for protection of staff and patients is available.	n	5	6	7	18	5	41
	%	12.2	14.6	17.1	43.9	12.2	100.0
Infection control strategy guidelines are available.	n	0	5	4	26	6	41
	%	0.0	12.2	9.8	63.4	14.6	100.0

** Missing value is 1*

Table 4.33: Extent to which nurse managers agree with management and leadership aspects (n=42)

MANAGEMENT AND LEADERSHIP		AGREEMENT (ON A SCALE OF 1 TO 4)				TOTAL
		DO NOT KNOW	DO NOT AGREE	TEND TO AGREE	FULLY AGREE	
Leadership style is the way in which the management philosophy manifests itself in practice.	n	7	5	10	17	39
	%	17.9	12.8	25.6	43.6	100.0
The leadership style of nurses in our country over the last 20 years has been one of democratic leadership.	n	5	17	13	5	40
	%	12.5	42.5	32.5	12.5	100.0
Problem solving is more successful when managed immediately by the supervisor, rather than involving the specific subordinates.	n	2	20	8	10	40
	%	5.0	50.0	20.0	25.0	100.0
Nurse managers should possess adequate communication skills.	n	0	1	6	33	40
	%	0.0	2.5	15.0	82.5	100.0
Due to the heavy workload of managers, it is not expected that they should have a training function.	n	2	30	6	2	40
	%	5.0	75.0	15.0	5.0	100.0
Patient care is the primary function of the manager; therefore personnel can be managed by the personnel department.	n	5	15	5	14	39
	%	12.8	38.5	12.8	35.9	100.0
Extrinsic motivation of employees involves stimulation of goal achievement.	n	5	3	11	20	39
	%	12.8	7.7	28.2	51.3	100.0
Management's leadership style has an effect on the level of performance inclination.	n	2	5	12	20	39
	%	5.1	12.8	30.8	51.3	100.0
A position of authority is required in management positions to ensure successful influencing of subordinates.	n	0	2	18	20	40
	%	0.0	5.0	45.0	50.0	100.0
Traditionally, nurse managers in Namibia have had an autocratic style of management.	n	5	10	14	8	37
	%	13.5	27.0	37.8	21.6	100.0
Participative management involves shared decision-making.	n	0	4	8	28	40
	%	0.0	10.0	20.0	70.0	100.0
Employees who receive frequent feedback concerning their performance are usually more highly motivated than those who do not.	n	0	3	5	32	40
	%	0.0	7.5	12.5	80.0	100.0

** Missing value varied between 1 and*

Leadership and management are important aspects when it comes to performance of nurses within the clinical wards. In support of this statement, more than half of the respondents (32; 82.1%) *tended to agree* or *fully agreed* that management and leadership style has an effect on the willingness of subordinates to perform well. Over half of the responses (27; 69.2%) *fully agreed* or *tended to agree* that the leadership style exhibited by managers is the way in which their management values and beliefs are expressed.

In determining the type of leadership in the nursing profession, Less than half of the respondents (18; 45.0%) *tended to agree* or *fully agreed* with the statement that the leadership style of nurses over the last 20 years has been democratic; 17 (42.5%) *did not agree,* while five (12.5%) *did not know*. With regard to the statement that the leadership style of nurses in Namibia has been traditionally autocratic, more than half (22; 59.4%) respondents *tended to agree* or *fully agreed*. According to Jooste (1996b:167), no one style of leadership should apply to all nursing situations. Leadership style should vary according to circumstances and should elicit specific behaviour that is needed to execute a task. However, whatever style is used, emphasis should be placed on the people who are performing the job.

The majority of nurse managers (38; 95.0%) *agreed* that a position of authority is required in management positions to ensure successful influencing of subordinates.

4.4.11 Organizational processes

This section contains information about the opinions on the functions and operations of the organization. It presents information about issues such as mission and goals of the organization, commitment to the organization and personal satisfaction, reward and recognition, interpersonal relationships, management style, and the social and cultural factors that may affect the performance of nurse managers at the workplace.

4.4.11.1 Mission and goals

Table 4.34 presents the responses made by nurse managers with regard to the mission and goals of the organization. Most of the nurse managers either *agreed* or *strongly agreed* that the organization's mission is understood by everyone who works there (17; 41.4%); that most people know that their work contributes to the organizations mission (23; 57.5%); and that they are clear about the objectives they need to achieve (27; 65.9%)

Table 4.34: Nurse managers' responses on organizational mission and goals (n=42)

MISSION AND GOALS	**AGREEMENT (ON A SCALE OF 1 TO 5)**						**TOTAL***
		STRONGLY DISAGREE	**DISAGREE**	**NEITHER AGREE NOR DISAGREE**	**AGREE**	**STRONGLY AGREE**	
Most people here know how their work contributes to this organization's mission.	n	3	8	6	17	6	40
	%	7.5	20.0	15.0	42.5	15.0	100.0
This organization's mission is understood by everyone who works here.	n	8	8	8	11	6	41
	%	19.5	19.5	19.5	26.8	14.6	100.0
I am clear about the objectives I need to achieve.	n	0	2	12	15	12	41
	%	0.0	4.9	29.3	36.6	29.3	100.0
People in this organization have a shared sense of purpose.	n	4	4	16	13	5	42
	%	9.5	9.5	38.1	31.0	11.9	100.0

** Missing values varied between 1and 2*

Table 4. 35: Nurse managers' responses on commitment and satisfaction (n=42)

COMMITMENT AND SATISFACTION	**AGREEMENT (ON A SCALE OF 1 TO 5)**						**TOTAL***
		STRONGLY DISAGREE	**DISAGREE**	**NEITHER AGREE NOR DISAGREE**	**AGREE**	**STRONGLY AGREE**	
I am proud to tell people that I work for this organization.	n	2	6	8	12	14	42
	%	4.8	14.3	19.0	28.6	33.3	100.0
I do not like the way this organization operates.	n	5	13	8	8	8	42
	%	11.9	31.0	19.0	19.0	19.0	100.0
This organization provides me with skills and knowledge that will benefit my future career.	n	3	6	15	10	7	41
	%	7.3	14.6	36.6	24.4	17.1	100.0
Doing this job makes me feel good about myself.	n	0	4	6	16	16	42
	%	0.0	9.5	14.3	38.1	38.1	100.0
I am subject to personal criticism or abuse at work.	n	7	16	11	8	0	42
	%	16.7	38.1	26.2	19.0	0.0	100.0
I am constantly seeking out new challenges at work.	n	0	8	9	15	10	42
	%	0.0	19.0	21.4	35.7	23.8	100.0

** Missing value is 1*

4.4.11.2 Aspects related to commitment and satisfaction

Table 4.35 consists of responses related to commitment and satisfaction**.** Most of the nurse managers show their commitment to the organization and satisfaction in working for the organization. Over three quaters of respondents (32; 76.2%) *agreed* or *strongly agreed* that doing this job (nursing) makes them feel good about themselves, and 26 (61.9%) respondents felt proud to tell people that they work for this organization. More than half (25; 59.5%) mentioned that they are constantly seeking new challenges. Less than half (17; 41.5%) stated that the organization provides them with skills and knowledge that will benefit their future careers.

4.4.11.3 Aspects related to performance

Table 4.36 presents responses related to performance**.** Most of the respondents either *agreed* or *strongly agreed* that the work they do contributes to the organization's performance (33; 80.4%); that judgement about their performance is fair (23; 56.1%); and that they are given enough authority to allow them to do their work (25; 61.0%).

However, almost half of the nurse managers (17; 41.5*%) neither agreed nor disagreed* that their manager emphasises their positive contributions when reviewing their performance. This is alarming, since it came from nurse managers.

Table 4.36: Nurse managers' responses on performance (n=42)

PERFORMANCE	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
My performance is judged more by how much work I do than by how well I do it.	n	5	10	6	17	4	42
	%	11.9	23.8	14.3	40.5	9.5	100.0
My manager emphasises my positive contributions when reviewing my performance.	n	3	5	17	11	5	41
	%	7.3	12.2	41.5	26.8	12.2	100.0
I am given enough authority to allow me to do my job effectively.	n	0	6	10	16	9	41
	%	0.0	14.6	24.4	39.0	22.0	100.0
People in this organization put more energy into identifying mistakes than into figuring out how to do things right.	n	5	11	8	10	8	42
	%	11.9	26.2	19.0	23.8	19.0	100.0
Judgement about my performance is fair.	n	1	7	10	20	3	41
	%	2.4	17.1	24.4	48.8	7.3	100.0
The way things are organised around here makes it hard for people to do their best work.	n	4	13	7	10	8	42
	%	9.5	31.0	16.7	23.8	19.0	100.0
I feel my work contributes to the organization's performance.	n	2	0	6	19	14	41
	%	4.9	0.0	14.6	46.3	34.1	100.0

** Missing value is*

Table 4.37: Nurse managers' responses on reward and recognition (n=42)

REWARD/RECOGNITION	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
I receive prompt acknowledgement and recognition for doing a good job.	n	7	13	7	9	5	41
	%	17.1	31.7	17.1	22.0	12.2	100.0
I find my work rewarding.	n	3	10	8	14	7	42
	%	7.1	23.8	19.0	33.3	16.7	100.0
The work I do gives me a feeling of personal achievement.	n	1	1	4	19	16	41
	%	2.4	2.4	9.8	46.3	39.0	100.0
When I retire I will receive a reasonable pension from this organization.	n	3	5	16	12	5	41
	%	7.3	12.2	39.0	29.3	12.2	100.0
My pay is competitive to other similar organizations	n	11	9	8	9	4	41
	%	26.8	22.0	19.5	22.0	9.8	100.0

* *Missing value is 1*

199

4.4.11.4 Aspects related to reward and recognition

Table 4.37 consists of nurse manager responses dealing with aspects related to reward and recognition. More than half of the nurse managers either *agreed* or *strongly agreed* that the work they do gives them a feeling of personal achievement (35; 85.3%) and that they found their work rewarding (21; 50.0%). However, 20 (48.8%) *strongly disagreed* or *disagreed* that they received prompt acknowledgement and recognition for doing a good job. Nearly half (20; 48.8%) of the nurse managers either *strongly disagreed* or *disagreed* that their pay is competitive to other similar organizations.

4.4.11.5 Aspects related to management style

Table 4.38 presents responses of nurse managers on aspects related to management style. Over half of the nurse managers either *agreed* or *strongly agreed* that they trust and respect their immediate supervisor (34; 82.9%); that their supervisor inspires them to do their best (22; 53.6%); that if they have an idea for improving the way they work, the supervisor will listen to them (21; 51.2%). However, 13 (31.7%) *neither agreed nor disagreed* that the supervisor listens. A third (16; 39.0%) either *agreed* or *strongly agreed* that senior managers in the organization are open to new ideas, while almost a third (13; 31.7%) *neither agreed nor agreed* with the statement. Just over a third (14; 34.2%) *strongly disagreed* or *disagreed* that their manager gives them regular, timely feedback that helps them to improve performance, while almost a third (13; 31.7%) *neither agreed nor disagreed* with the statement.

Table 4.38: Nurse managers' responses on aspects related to management style (n=42)

MANAGEMENT STYLE		AGREEMENT (ON A SCALE OF 1 TO 5)					TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
My manager/supervisor inspires me to do my best.	n	2	9	8	16	6	41
	%	4.9	22.0	19.5	39.0	14.6	100.0
When changes are made in the way things are done, management always first informs the people who will be affected.	n	8	5	9	12	7	41
	%	19.5	12.2	22.0	29.3	17.1	100.0
If I have an idea for improving the way we do our work, my supervisor/ manager will usually listen to me.	n	4	3	13	14	7	41
	%	9.8	7.3	31.7	34.1	17.1	100.0
My manager/supervisor gives me regular, timely feedback that helps me improve my performance.	n	4	10	13	10	4	41
	%	9.8	24.4	31.7	24.4	9.8	100.0
I am afraid to openly express my ideas and opinions.	n	9	16	3	8	6	42
	%	21.4	38.1	7.1	19.0	14.3	100.0
Senior managers in this organization are open to new ideas and suggestions.	n	2	10	13	11	5	41
	%	4.9	24.4	31.7	26.8	12.2	100.0
I trust and respect my immediate supervisor.	n	0	1	6	21	13	41
	%	0.0	2.4	14.6	51.2	31.7	100.0

***** *Missing value is 1*

Table 4.39: Nurse managers' responses on interpersonal relations (n=42)

INTERPERSONAL RELATIONSHIPS	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL*
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
In this organization, people in different departments or programmes try to help each other.	n	0	6	7	20	8	41
	%	0.0	14.6	17.1	48.8	19.5	100.0
I work with skilled competent people who are good at their jobs.	n	3	8	7	21	3	42
	%	7.1	19.0	16.7	50.0	7.1	100.0
The people I work with are comfortable in suggesting changes and improvements to each other.	n	3	8	12	12	6	41
	%	7.3	19.5	29.3	29.3	14.6	100.0
There is a great deal of cooperation between people in this organization.	n	2	5	14	14	6	41
	%	4.9	12.2	34.1	34.1	14.6	100.0
My colleagues value my contribution.	n	1	1	11	20	8	41
	%	2.4	2.4	26.8	48.8	19.5	100.0
I am not included in hospital/ward activities or made to feel part of the team.	n	12	19	4	6	1	42
	%	28.6	45.2	9.5	14.3	2.4	100.0

***** *Missing value is 1*

4. 4.11.6 Aspects related to interpersonal relations

Table 4.39 consists of nurse manager responses on aspects related to interpersonal relations. There seems to be positive interpersonal relations between managers and the professional nurses they are supervising as indicated by the responses of nurse managers that they *agreed* or *strongly agreed* that people in different departments or programmes try to help each other (28; 68.3%); that colleagues value each other's contributions (28; 68.3%); and that there is a great deal of cooperation in the organization (20; 48.7%). Furthermore, over half (24; 57.1%) of the nurse managers either *agreed* or *strongly agreed* that they work with competent people who are good at their jobs, while 18 (43.9%) *agreed* or *strongly agreed* that the people they work with are comfortable with each other. This is consistent with the professional nurses' responses in table 4.17.

4.4.11.7 Aspects related to social and cultural factors

Table 4.40 consists of nurse managers' responses related to aspects of social and cultural factors. Just over half of the respondents (22; 52.4%) either *agreed* or *strongly agreed* that the community they lived in has the highest regard for their organization, while less than a third (11; 25.2%) either *strongly disagreed* or *disagreed*.

Table 4. 40: Nurse managers' responses on aspects related to social and cultural factors (n =42)

SOCIAL AND CULTURAL BELIEFS AND FACTORS	AGREEMENT (ON A SCALE OF 1 TO 5)						TOTAL
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	
Some cultural beliefs in the community I am living are in conflict with some my organization policies.	n	7	14	7	8	6	42
	%	16.7	33.3	16.7	19.0	14.3	100.0
The community I live in has the highest regards for my organization	n	2	9	9	11	11	42
	%	4.8	21.4	21.4	26.2	26.2	100.0

4.4.12 Open- ended questions

Nurse managers were asked in open-ended questions to indicate *what they like most about working for their organization*, *what they like least* and *what they would like to see changed or improved*.

Nurse managers provided more than one response to these questions; however, not all nurse managers responded to all open-ended questions.

4.4.12.1 Aspects that nurse managers like most or like least about working for their organization

Table 4.41 presents the common responses from nurse managers on issues they like about working for their organization.

Table 4.41: Nurse managers' responses about what they like most about working for their organization (n=42)

ISSUE	n	%
Caring for sick and helpless patients	18	42.8
To practice my profession	11	26.0
Cooperation and team work	10	23.8

There is some consistency with the professional nurses' responses where the majority of nurse managers (18; 42.8%) mentioned that what they like about the organization is caring for the sick and helpless. It is satisfying to see that nursing still remains a caring profession.

Table 4.42 presents the common responses from nurse managers on issues they like least about working for their organization.

Table 4.42: Nurse managers' responses about what they like least about working for their organization (n=42)

ISSUE	n	%
Lack of equipment and supplies	7	16.6
Poor management skills	7	16.6
Poor communication	6	14.2
Overtime regarded as money-making business	10	23.8
No recognition for work rendered	10	23.6

On the question about what they like least about the organization, nurse managers mentioned no recognition for the work rendered (10;23.8%); overtime payment being regarded as a money-making business (10;23.8%); lack of equipment and supplies (7;16.6%); and poor communication (7; 16.6%). Some individual responses from nurse managers include:

"I am tired to hear of money shortages from government".

"Weak management and leadership skills".

"The organization is mismanaging the resources, i.e. financial resources; over expenditure is the main problem, because by the end of the financial year some benefits have to be cut off".

4.4.12.2 Aspects that nurse managers would liked improved or changed

Improvement of performance of nurse managers should be an ongoing activity. Nurse managers provided valuable information on what needs to be changed and improved. Table 4. 43 contain only the common responses from nurse managers on what they would like to see changed or improved.

Table 4.43: Nurse managers' responses about what they would like to see improved or changed (n=42)

ISSUE	n	%
Recognition of additional training	10	23.6
Renovation of hospital	6	14.2
Recognition and valuing of hardworking nurses	14	33.3
Improve opportunities for in-service training/skills development and opportunities to attend workshops	14	33.3
Salaries and remuneration package to be improved	7	16.6
Improved feedback from managers on performance	6	14.2
New equipment or sufficient equipment	8	19.0

Most of the nurse managers felt that opportunities for skills development and in-service training should be created (14; 33.3%); hard work should be valued

and recognised (14; 33.3%); and additional training (10; 23.6%) should be recognised.

4.5 CONCLUCION

In this chapter, the results of questionnaire 1 and questionnaire 2 were presented and discussed. Questionnaire 1 was completed by 147 professional nurses, while questionnaire 2 was completed by 42 nurse managers. A broad variety of aspects associated with factors affecting the performance of nurses were covered. They include human resources management and development issues, particularly related to management of professional nurses; aspects related to the knowledge and skills as well as management skills of professional nurses in supervisory and management position; and aspects related to the organization processes that influence the performance of nurses.

Analysis of data revealed the opinion and views of professional nurses and nurse managers with regard to those factors related to the organization and those related to individuals that positively or negatively affected their performance. The data also revealed some suggestions made for improving and changes that need to be made to ensure enhanced performance.

From this information, conclusions and recommendations could be formulated as presented in Chapter 5.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter contains conclusions and recommendations. This study originated from the evidence and recognition that by far the most significant component of health systems is health personnel. Without a foundation of skilled human resources for health, health care systems cannot function adequately or effectively. It is widely recognised that health workers are not providing the desired output in relation to health interventions. Many countries, including Namibia, echoed this concern; with the current status of health personnel in terms of quality of nursing care and productivity, this is regarded as one major constraint in achieving the Millennium Development Goals (High-Level Forum on Health MDGs 2004:2).

It was established from the literature that the nursing workforce is not performing in ways that are responsive and efficient, and, therefore, they are not providing quality care. The literature also revealed some actions and solutions to achieve the outcomes: improving working conditions, improving motivation, productivity, quality of health care, development and strengthening of clinical and management skills, training sufficient health personnel, better remuneration and incentives.

It was also established that nurses made up the majority of health personnel (71%) in the Ministry of Health and Social Services (MOHSS 2004b:3). This means the country heavily relies on nurses to deliver health care. Their performance is therefore critical for successful provision of quality health care.

It is against this background that the study was undertaken to identify and analyse factors that negatively and positively affect the performance of professional nurses in Namibia; a second objective was to suggest strategies for monitoring and improving performance.

More specifically the objectives of the study were to:

- Determine the factors which positively or negatively affect the performance of professional nurses;

- Identify the skills and competencies of nurse managers in order to facilitate good performance of their subordinates;

- Propose strategies that could improve performance of professional nurses;

This study relied on the Performance Model, which is a combination of Bennett and Franco's (1999) model of motivation and Sharpley's (2002) model on perception, motivation, performances and the human resources management practises affecting the performance of health workers. This

chapter presents the conclusions obtained from the results of the study and the recommendations to improve performance of nurses.

5.2 CONCLUSIONS

The study clearly established some of the factors that contribute to both positive and negative performance of professional nurses in the Oshana, Onandjokwe and Khomas regions. The conclusions will be presented under the following headings: *general factors affecting the performance of professional nurses* and *management factors affecting the performance of professional nurses.*

5.2.1. General factors affecting the performance of professional nurses

The first objective of the study was to identify factors that positively and negatively affect the performance of nurses. The aspects that have emerged from the study include a broad range of negative (demotivators) and positive (motivators) factors which lies within the individual or the organizational structure/processes and are discussed in detail below.

5.2.1.1 Aspects related to knowledge and skills base

Nearly a third of the professional nurses responded that they have average skills in conducting in-service training, counselling of patients and self assessment (Table 4.3). Respondents also reported that they required skills in aspects related to improving the quality of care. These are important skills needed by each and every professional nurse. They also critically need skills for supervising students and providing in-service training. In the four teaching hospitals surveyed, student nurses are allocated for practical experience and mentoring to become professional nurses. Furthermore, Namibia is not spared from emerging diseases such as HIV/AIDS. Professional nurses provide counselling and care for patients as well as colleagues who are affected or infected by the virus. It is therefore crucial to develop strategies that will address the skills gap in the clinical wards.

The availability of quality health services and nursing care to promote health, prevent ill-health or care and rehabilitate patients and clients depend on the knowledge, skills and motivation of health personnel (High-Level Forum on Health MDGs 2004:10).

5.2.1.2 Aspects related to performance appraisal and utilisation thereof

Despite the importance of measurement and evaluation of performance of employees, the study revealed (tables 4.5 and 4.27) that performance appraisal is not conducted in most institutions. In most cases, it was revealed that performance appraisal is done in an informal and *ad hoc* manner. It can be assumed that no formal appraisal is in place in most of the wards to identify skill gaps or good performance. It can be concluded that reports with information of the level of performance of individual professional nurses and nurse managers do not exist. According to Sutherland et al (1995:12), if you cannot measure something, you cannot control or improve it.

It is therefore not surprising that most respondents (tables 4.7 and 4.28) indicated that they are not given feedback on outcomes of performance appraisal throughout the year. Furthermore, employees are not given opportunities for self assessment or to make comments on their performance outcome report. It can be concluded, therefore, that no formal monitoring of performance exists in clinical wards.

It is also evident that employees want to be recognised as individuals. They appreciate feedback and find it reassuring, but they also felt that they have the right to make comments on the results of their performance appraisal. This is supported by Swansburg and Swansburg (1999:694)

who indicated that monitoring performance to enhance performance, productivity and quality of nursing care means continuously assessing performance of employees, providing support and feedback of shortcomings and strengths, and jointly agreeing on how to address any deficiency detected. Equally important is that appraisal motivates and re-enforces those who are performing well.

5.2.1.3 Aspects related to remuneration, benefits, reward and recognition

Almost half of both groups of respondents were not satisfied with their remuneration and held the opinion that it was not competitive with similar organizations (tables 4.8 and 4.29), while 17% of the nurse managers and 27% of the professional nurses were uncertain in this regard. It can be concluded that this factor got balanced responses, that though half of the respondents were not happy, 27% were of the opinion that their remuneration was competitive, and a third of the respondents felt that their remuneration was in general not poor. The assumption can be made that remuneration in the form of salaries and other incentives is an important factor in retaining health workers (Awases et al 2004: 54).

With regard to career advancement, most of the respondents were of the opinion that career advancement was poor, that nurses are not recognised for the work done and for additional qualifications acquired. The above is supported by Sharpley (2002:4), Nickols (2003:2-3) and Fort and Voltero

(2004:3) who state that individual perception such as anticipation of success, job satisfaction through praise and recognition, and empowerment are factors associated with high performance.

It is encouraging to note that most of the nurse managers and professional nurses are of the opinion that the work they are doing gives them a feeling of achievement (tables 4.13 and 4.37) and that they find their work rewarding. On the other hand, half of the respondents (55.1% professional nurses and 48.8% nurse managers) are of the opinion that they don't get acknowledgement and recognition for doing a good job. It can be concluded that respondents feel that acknowledgement and feedback on their performance serve as positive encouragement and reassure them that their contributions are important and appreciated. Bennett and Franco (1999:9) and Nickols (2003:2) consider acknowledgement, supervision and feedback as some of the strongest motivating factors.

5.2.1.4 Staffing and work schedule

It is encouraging to note that both groups of respondents provide a balanced view of the overall work schedule (tables 4.9 and 4.30): almost half of the respondents indicated that the overall work schedule is fair and work hours are flexible. It must be noted that less than a third (24.5%) were uncertain. It can be concluded that though nearly half of the respondents seems to be satisfied, this is one factor that can be revisited and successfully resolved between the hospital management and all

nurses concerned to ensure that everyone agrees with the work schedule provided.

To ensure that quality nursing care is provided to patients in wards, it is important that sufficient numbers of nurses with the appropriate skills are available in the wards (WHO 1998:4). However, more than half of the respondents felt that the number of staff allocated to their wards is inadequate as confirmed by their written responses to open-ended questions. Some said that they have a heavy workload due to staff shortages. Thus it can be concluded that there are insufficient professional nurses allocated to wards to provide nursing care. The High-Level Forum on Health MDGs (2004:3), Loewenson and Thompson (2004:5), and Erasmus and Brevis (2005:54) confirm that shortage of staff is one of the major constraints in delivering health care services.

It is disheartening to note that the majority of nurse managers and professional nurses indicated that despite the heavy workload, care and support of staff in the form of counselling is not available.

5.2.1.5 Staff development

The staff development programme in an organization is designed to ensure that staff knowledge and skills are developed, strengthened and kept up to standard to ensure excellent care of patients (Swansburg & Swansburg 1999:570; Price 2000:348; Booyens 1993b:375). In contrast to

this statement, less than half of the professional nurses (44.1%) are of the opinion that continuous education opportunities exist, while 50.0% of nurse managers thought opportunities were not available (tables 4.10 and 4.31). Furthermore, only 32.4% of professional nurses are of the opinion that the in-service training provided addresses the skills gap compared to 53.6% of nurse managers. It can therefore be concluded that staff development programmes are inappropriate and irrelevant. It is critical that this factor be addressed.

It is disconcerting to note that both groups (61.8% professional nurses, 47.6% nurse managers) do not support the statement that incompetent nurses are identified and provided with necessary support. However, this is not surprising, following the responses (tables 4.5 and 4.27) that formal performance review systems are not available.

5.2.1.6 Workspace and environment

Both groups of respondents are of the opinion that materials and supplies are insufficient and that instruments are not in working condition (tables 4.11 and 4.32). This is supported by written responses of respondents who indicated that the authorities need to purchase modern and new equipment, and that speedy repairs and maintenance of equipment is essential.

The assumption can be made that the physical conditions are not conducive to work and that they constrain employees in providing quality care. This is

confirmed by Awases et al (2004:54) who state that factors that motivate health workers to stay in their organizations include aspects of working conditions such as availability of proper work facilities and equipment.

It is, however, encouraging to see that both groups (66.6% professional nurses, 78.0% nurse managers) felt that infection control aspects are being addressed: they felt that infection control strategy guidelines are available.

5.2.1.7 Mission and goals

It is encouraging to note that the majority of both groups of respondents indicated that that they are clear about the objectives to be achieved and that their work contributes to the objectives of the organization (tables 4.12 and 4.34).

It can be assumed that the goals and objectives are known and that respondents are aware that their day-to-day activities, duties and tasks are linked to the overall performance of the organization. This is supported by Bennett and Franco (1999:8) and Nickols (2003:2) who concluded that employees should know the goals and mission of the organization as well as their own job objectives and expectations in order to contribute to the overall goals of the organization.

5.2.1.8 Commitment and satisfaction

Nursing is a calling. Despite constraints such as heavy workload, low salaries and insufficient materials, there are still nurses who show professional pride and are ready to serve the nation (McCourt & Awases 2005:7). This is supported by the responses from both groups indicating that they are committed to the organization and that being a nurse makes them feel proud about themselves (tables 4.14 and 4.35).

5.2.1.9 Leadership and management

Leadership and management styles are very important issues when it comes to ensuring high performance levels by professional nurses as well as nurse managers. It is therefore encouraging to note that the majority (80.0%) of both groups of respondents indicated that they trust and respect their immediate managers and supervisors who inspire them to do their best (tables 4.15 and 4.33). However, only 38.8% of professional nurses felt that they are consulted and informed when changes are made in the way things are done by management compared to 46.4% of nurse managers. It can be concluded that leadership and management styles of senior nurses in the organization have a significant effect on the performance outcomes of their subordinates.

5.2.2 Management factors affecting the performance of professional nurses

The professional nurses in management positions require certain important skills to successfully manage the ward or the services under their control in order to facilitate good performance of subordinates. The aspects related to management skills of professional nurses are discussed below.

5.2.2.1 Management skills and competencies

Management skills are very critical for nurse managers as they interact and engage with the staff during the planning, directing, managing, implementing and monitoring of services and care (Robbins & Coulter 2002:10). The majority of nurse managers are of the opinion that they have experienced and executed activities related to orientation of staff, training, placement and managing of conflict (table 4.22).

However, some of the nurse managers indicated that they have not experienced or been involved in executing some very important activities such as one-to-one performance interviews with subordinates (61.1%) or operational research (52.4%). It can be concluded that nurse managers do not have enough exposure and involvement in all management functions.

5.2.2.2 Management related training

With regard to management training, related additional training, and qualifications, most nurse managers indicated that they have received training, while a significant number (35.7%) indicated that they have not received any training (Table 4.24). It is regrettable that such a percentage of nurse managers are without any additional preparation for a higher level of nursing functions.

5.2.2.3 Knowledge base and skills of nurse managers

With regard to nurse managers' knowledge and skills, there were balanced views between good and average skills with about half of them rating themselves as having sufficient knowledge and skills in implementing nursing service policy, planning nursing services, skills development, supportive supervision, motivation of staff and problem solving. Furthermore, a third of the nurse managers rated their knowledge and skills as average in development of nursing standards, performance appraisal of subordinates, planning nursing services delivery, nursing audit and motivation (Table 4.26).

This is a very distressing outcome, and it can be concluded that some nurse managers are not skilled enough to plan and oversee the implementation of nursing services or to support and guide the professional nurses under supervision. It is therefore important to establish a mechanism that will

strengthen the knowledge and skills of nurse managers to be able to supervise those working within the wards as well as translate health policies and plans into action (WHO 2004:8).

5.3 RECOMMENDATIONS

The results revealed the factors affecting the performance of nurses. These factors need to be addressed over a period of time (5-10 years) to ensure gradual sustainable progress in improving the performance of nurses within a changing health environment. Table 5.1 presents a framework for developing and improving performance of nurses. The framework proposes broad areas to be addressed with possible strategies that could be implemented or adapted according to needs of the region, hospital and institution.

The framework consists of activities related to advocacy; strengthening of knowledge and expertise; development of leadership and management skills; development of mechanisms for enhancing and improving performance, including skills for performance management; generation of information and knowledge through information systems and research on the nursing profession.

The following are important issues when considering implementation of the proposed strategies listed in the framework:

- What strategies and activities are most likely to succeed or have an impact?
- Are the human and financial resources available for implementation?
- What should be implemented in the immediate term (1 year), medium term (2-5 years) and long term (5+ years)?
- How can other partners be mobilised to contribute?

Table 5.1 Framework for developing and improving performance of nurses

Key Result Area	Strategies
1. Enhancement and development of the nursing profession	▪ Advocacy and awareness campaigns for recognition of nursing profession ▪ Development of tools and marketing materials for advocacy and marketing of the nursing profession ▪ Strengthening relationships with relevant professional bodies, unions or associations
2. Building knowledge and expertise	▪ Enhancing continuous professional development of nurses ▪ Strengthening in-service training programmes ▪ Development of skills development programme, especially clinical nursing specialities. ▪ Development of short courses to address the skill gap
3. Development of mechanisms for enhancing the performance of health workers	▪ Development of nursing care indicators ▪ Development of nursing skills for performance appraisal ▪ Development of supervisory and feedback skills ▪ Development of motivation strategy (include aspects such as recognition, incentives, career path development, working conditions) ▪ Advocate for increasing the number of nurses

4. Development of leadership and management capacity	▪ Developing a plan for leadership and management capacity. ▪ Management competencies and skills development courses ▪ Improvement of communication processes
5. Research, information and evaluation	▪ Development of a comprehensive research agenda ▪ Strengthening of research capacity and skills building courses ▪ Mobilisation of financial resources for conducting research by nurses within their hospitals and wards ▪ Definition of indicators for monitoring progress of nursing development in Namibia

Discussions will follow explaining the principle aspects listed in the framework (table 5.1)

5.3.1 Strategies to improve performance of professional nurses

There are obviously no prescriptions and standard templates available to address the issue of improving performance of professional nurses in Namibia. However, some strategies are proposed in the form of broad strategic actions to address the strengthening and performance nurses.

5.3.1.1 Enhancement and development of the nursing profession

- *Advocacy and marketing the nursing profession*

There is a need to make the nursing profession visible. It should portray a positive image of the caring roles of nurses to communities, clients, patients, the authorities. This can be done through developing advocacy materials with positive messages and images of nursing. Nursing associations and boards are strategically placed to lead this activity. Furthermore nursing leadership should be strengthened to be able to effectively communicate with decision-makers and lobby with interested parties to affect necessary changes in nursing services and needs. This can be done by organising workshops for training nurses in negotiation and lobbying skills.

- *Strengthening relationships with relevant professional bodies, unions and associations*

Relations between nursing services, professional nurses and the stakeholders such as Namibian Nursing Board, the Namibia Nursing Association and the relevant workers union should be strengthened. Regular meetings with the above stakeholders should be held to discuss strategies on how to enhance the nursing profession.

Nurse managers in hospitals can take the lead in reaching out to stakeholders in their respective regions. However, the sub-division, Nursing Services at the Head Office of the Ministry of Health and Social Services responsible for

overseeing nursing in the country should establish a mechanism for reaching out to all relevant stakeholders. This can include organization-based training courses, or distance learning courses.

5.3.1.2 Building knowledge and expertise

Professional nurses require up-to-date knowledge and skills to perform well. The current disease profile and changing health systems make this need more essential today. The emphasis should be placed on the concept of promoting life-learning.

- *Continued professional development*

A continuous education programme is necessary to ensure that nurses are proficient with regard to their knowledge and skills as well as responsive to changing needs in the health sector. The sub-division, Nursing Services at the Ministry of Health and Social Services Head Office at National level responsible for overseeing the nursing services in the country should develop a programme and encourage professional nurses to develop themselves and thus enhance the nursing profession.

- *In-service training programme*

To ensure that both professional nurses and nurse managers are kept up-to-date with the needs of the organization, and in-service training programme

should be developed by the Nursing Personnel Development Units in the hospitals. In-service training is most likely to change nurses' behaviour when it is interactive, based on real-life problems and combined with continuing, intermittent support. The programme may consist of short courses, workshops and long-term courses. The National Health Training Centre (NHTC), which falls under the Ministry of Health and Social Services, may be commissioned to develop some of the courses needed.

Some of the crucial content for short courses, as indicated by the respondents, should include performance appraisals and feedback mechanisms, counselling skills, managing of conflict, development of nursing performance standards, nursing audit, operational research, training and guiding of students, improving quality of nursing care.

- *Clinical specialisation*

Clinical specialisation is important and very crucial to ensure high quality of care in different disciplines. Each nursing discipline should have at least two clinical nurse specialisations, for instance paediatric and oncology nursing. This could be achieved by presenting a plan for developing clinical nursing specialisations to the Ministry of Health and Social Services Fellowship Committee to ensure inclusion of nursing cadre needs in the Fellowship plan submitted for funding to organizations such as the World Health Organization.

5.3.1.3 Developing mechanisms for performance enhancement of nurses

From the results of the study, it is apparent that the issues related to performance of nurses and midwives are multifactoral. To ensure that the corrective actions will be feasible and achievable, it is important to involve all stakeholders (nurses, management and regulatory bodies) in identifying the strategies to be employed in the short, medium and long term.

- *Performance appraisal and management*

Performance appraisal is a crucial function of performance management and a vital method for assessing the outcome of individual contributions to an organization's objectives. Currently no standardised system of performance appraisal exists and such appraisal is not enforced in all clinical wards. It is therefore important to advocate for reinstatement of the Public Services Performance appraisal system. Moreover, there is a need to strengthen the organizational performance management systems in general and the nursing management systems within the Ministry of Health and Social Services in particular.

It is also necessary to develop specific performance improvement plans with specific monitoring and evaluation targets for each level of nursing care as well as programmes that will provide skills for performance appraisal and feedback of outcomes to nurse managers. This task could be taken forward

by the Personnel management and the Human Resources Development Division in collaboration with all the regions, including the professional nurses.

- *Development of performance standards*

As part of the performance appraisal system, standards for nursing care should be developed along with indicators and targets for effective monitoring of implementation thereof. The Nursing sub-division at national level could take up this challenge and in collaboration with the Nursing Board could develop standards for nursing care in the public health facilities. A workshop to develop nursing standards could be organised.

- *Management of human resources in nursing*

Better understanding of and involvement in human resource management issues are required from all levels of management. Nurse managers need exposure to and skills in issues such as recruitment, induction and orientation, and job descriptions for various cadres with clear responsibilities and authority lines, and managing a performance appraisal system. The nurse supervisor has responsibility to ensure that all new employees are introduced to their new work environment. It is suggested that nurse supervisors should have skills with regard to human resource management issues and this should be dealt with in the in-service training programme.

- *Motivation*

It is clear that health worker motivation is a determinant of performance and is believed to influence directly performance of individuals or intercede in the effect of other factors. Motivation can be achieved through monetary rewards such as improved salaries and benefits or non-monetary rewards. Since the salary improvement aspect is a very complex issue and out of the control of the Ministry of Health, it is recommended that non-monetary innovative strategies be developed to motivate nurses. These strategies could include recognition and reward of health workers, knowledge and expertise building, management style, career development and promotion. Another suggestion is to develop a package of incentives that includes individual financial and non-financial incentives.

- *Remuneration and incentives*

Obviously any issue of raising salaries depends on the recommendations of the Public Services Commission. It is therefore recommended that health authorities, regulatory bodies and unions advocate and encourage some changes whenever reviews of remuneration are done. For example, the level of remuneration of nursing personnel should be reasonable, commensurate with the work done and responsibilities taken and comparable to equivalent jobs in the country. Secondly, consideration could be given to scarce-skills allowances, and nurses should be compensated for taking on heavy workloads and working in mentally-tasking areas such as intensive care units,

psychiatric or mental health units, nursing management, or HIV/AIDS and counselling clinics. Thirdly, attention should be given to the development of a better career path within the clinical disciplines to retain nurses in clinical areas.

- *Recognition and rewarding of professional nurses.*

Recognition is seen as a key factor that may enhance productivity and job satisfaction and eventually improve the performance of professional nurses. It is recommended that strategies for acknowledging, recognising and rewarding professional nurses, including other front-line workers, should be developed.

Authorities should recognise and acknowledge nurses who are doing a good job under difficult conditions and not only mention the bad attitudes of nurses. This could be done by involving the nurses themselves in devising reward strategies. Some strategies could be borrowed from the private sector, for example, identifying the best health workers of the year and acknowledging them nationally, issuing leave for those working in stressful clinical areas for rest and recuperation, or giving a yearly prize to the best nurse per region or hospital within the normal public services management guidelines.

- *Work conditions and environment*

A safe physical environment free from hazards contributes to job satisfaction and motivation. The Ministry of Health and Social Services should ensure the

availability of basic supplies and materials, maintenance of equipment and replacement of old equipment, appropriate protective wear such as gloves and routine immunisation against hepatitis B.

Flexible working hours should be ensured. Choice of shift or work schedule is another way of improving job satisfaction and enhancing performance and the hospitals should discuss and agree on work schedules which take into account prevailing situations such as distance to the workplace and availability of transport to and from work.

- *Increasing the numbers of nursing cadres*

The increasing demand of health care in Namibia means that the Ministry of Health and Social Services and its partners should develop initiatives to meet the demand for more nurses and alleviate the workload from the existing nurses. It is necessary to train a critical mass of sub-professional nurses, such as enrolled nurses, to lessen the workload of professional nurses. Authorities should look into training lower level health care workers such as aide workers, lay workers or community health workers to focus on specific single interventions such as counselling, health education and immunisation campaigns.

5.3.1.4 Development of leadership and management capacity

- *Leadership development*

An important aspect of improving performance is the effective leadership skills of managers. Although there is some improvement in the management style, the autocratic approach is still evidenced in nursing today. In the current changing environment where the individual's rights are recognised, it is important for the creation of an environment that enables participation in management and decision-making. It is also important for the leader to have some emotional commitment to staff, and encourage them to do their best. To this end leadership courses which discussed the different styles of leadership and their implications should be organised by the Sub-division nursing services. One such course is the International Council of Nurses (ICN) Leadership for Change Programme which aims at developing nurses as effective leaders and managers in a constantly changing environment.

- *Development of management skills*

There is an increasing recognition that managerial skills are important in making health systems work. Concerted efforts should therefore be made to develop and update the skills of nursing managers at all levels of health care.

In order to ensure effective strengthening of nursing services and care, it is important to employ a participatory approach in the organization to ensure

that nurses are involved and consulted on issues regarding their work. Effective participation involves shared interest, improved coordination and communication. Given the pivotal role nursing practitioners play within the health care delivery systems, their expertise should be called upon when decisions are made about enhancing the efficiency of health services.

Programmes that will help to develop nurses as effective leaders and managers in a constantly changing environment should be developed and implemented. It is also suggested that a tailor made course be developed and that every nurse in a supervisory or management position should attend such a course to prepare them for this important role.

- *Interpersonal relations and communication*

Interpersonal relations and communication skills, including counselling skills, are very crucial and important aspects of nursing. It is recommended that professional nurses and nurse managers should undergo at least one course on counselling and interpersonal skills to enhance communication skills. These skills are now seen as highly necessary for all health workers. To ensure that a critical mass of professional nurses and nurse managers is equipped with skills, a course for training of trainers in counselling and interpersonal skills could be institutionalised at the National Health Training Centre for selective trainers who can then conduct courses in their respective hospitals.

- *Supportive supervision*

If executed correctly, supervision could be a mechanism for encouraging professional development and improving worker job satisfaction and motivation. It is necessary to encourage and advocate for institutional supportive supervision by introducing clear guidance on how to conduct supportive supervision. Tasks such as nursing audits should be done regularly, and the audit report should be used to identify gaps in nursing care. It is suggested that supervisors should be empowered by strengthening supervisory skills and developing tools and plans for supervision. Feedback skills are also very important. Short courses or in-service training programmes for professional nurses especially nurse managers should be organised.

5.3.1.5 Research, information and evaluation

The global evidence for nursing services has been growing steadily, but is still in the early stage. The available research evidence is linked to educational aspects such as teaching and curricula and skewed towards developed countries (WHO 2006:139). It is therefore important to advocate and promote research on the relationship between health workforce particularly nursing services and health outcome.

- *Production of nursing knowledge*

It is important to advocate for more and rigorous clinical research to expand and consolidate evidence on nursing and midwifery practice and evidence supporting community nursing. Enormous efforts should be made to investigate nursing services in Namibia in the context of health care delivery systems. For example, research could explore effective models that would contribute to providing quality of nursing care. A major barrier for research is insufficient financial resources for nursing services research, insufficient technical skills for conducting research by nurses themselves and lack of nursing research institutions.

A comprehensive research agenda for strengthening the availability of scientific knowledge for nursing services development should be developed nationally. This agenda should include aspects such as:

- Strengthening the research knowledge and skills
- Identification of critical areas for research
- Development of a plan for mobilising financial resources.

5.4 RECOMMENDATIONS FOR FURTHER RESEARCH

The following issues should be considered for further research**:**

- Cost-effectiveness trials of strategies to achieve and maintain high-quality performance of the organization of staff
- Perception of clients and patients on the quality of care received
- Best practice models in nursing and midwifery care models
- Assessment of nursing curriculum for relevance and appropriateness to current health needs
- Study of the current scope of nursing practice and its relevance to the changing and evolving environment.
- Further research is needed to validate these results in other countries. A comparative study in a few countries could be conducted by agencies such as the World Health Organization.

5.5 LIMITATION OF THE STUDY

It appears as if some of the older nurses who received training in Afrikaans could have some language barriers and still struggle with some of the terminology in relation to English. This was indicated by the fact that at some of the hospitals older nurses asked for more clarification in Afrikaans about the meaning of some of the terms.

All aspects related to factors affecting performance of professional nurses may not have been dealt with during this study. However the study results and the instruments developed may serve as a baseline for further research that may address aspects that may have been overlooked during this study.

Initially, comparison of data between private and public hospitals was considered needed, however due to the small number (20;27.2%) of respondents from private hospital comparison in this case was not seen as useful. Instead the views of professional nurses were considered regarding whether they were from private or public hospitals.

5.6 POST SCRIPT

The purpose of the study was to eventually provide a framework for improving the performance of professional nurses. The study followed a quantitative approach and exploratory design to analyse and describe the identified variables.

Findings of the study contributed to further understanding of the factors affecting the performance of nurses and midwives; however, further work needs to be done in this area. The study revealed that hospitals currently have deficiencies in human resource management, performance management and appraisal, staff and skills development, and work environment.

Regardless of the negative factors, the study indicated that nurses affirmed their commitment and professional pride. They indicated that they are proud

to be nurses despite all the problems constraining their work. Respondents also displayed a positive attitude towards the study.

The findings of the study have implications for the key stakeholders: Ministry of Health and Social Services, Nursing Health Profession Board, Namibia Nursing Association and nursing services. It is suggested that the relevant stakeholders in the country should discuss the issues and recommendations of the study with the view of addressing some of the critical issues presented.

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APPENDIX 1

Dr Kalumbi Shangula
The Permanent Secretary
Ministry of Health and Social Services
Luther Street, Windhoek West
Windhoek
Namibia

07 December 2005

Dear Dr Shangula

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN NAMIBIA AS PART OF THE D Litt et Phil STUDIES AT UNISA.

I am a Namibian, employed by the World Health Organization, Regional Office for Africa in Brazzaville Congo. I am registered with the University of South Africa (UNISA) for a doctoral degree. The title of the intended thesis is "*Factors affecting performance of professional nurses in Namibia*" I am expected to undertake research as part of the fulfillment of the requirements for the degree of D Litt et Phil degree at the University of South Africa.

The purpose of this study is to identify and analyze factors that negatively and positively affect performance of professional nurses in Namibia and to explore factors that are strongly associated with improved performance in order to suggest strategies for monitoring and improving their performance.

I am writing to seek permission to undertake research in Namibia. I have been awarded special leave for the month February - March 2006 and would like to commence with data collection in February 2006. The sample will be drawn from hospitals in Oshana, Otjozondjupa and Khomas regions.

Please find attached, copies of the proposal and two provisional questionnaires for your perusal. Your favorable consideration will be much appreciated.

Yours sincerely

Ms Magdalene H. Awases

Local mailing address: P O Box 21748, Windhoek *Tel. 264 811286393*

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APPENDIX 2

The Managing Director
Roman Catholic Hospital
92 Stubel Street
Windhoek

13 February 2006

Dear Sir/Madam

REQUEST FOR PERMISSION TO SUBMIT QUESTIONNAIRES TO PROFESSIONAL NURSES AND NURSE IN SUPERVISORY POSITIONS.

I am currently busy with research for the degree D Litt et Phil at the University of South Africa. The title of the intended thesis is ""*Factors affecting the performance of professional nurses in Namibia*" The study is undertaken towards the fulfillment of the requirements for the degree of D Litt et Phil degree at the University of South Africa.

The purpose of this study is to identify and analyze factors that negatively and positively affect performance of professional nurses in Namibia and to explore factors that are strongly associated with improved performance in order to suggest strategies for monitoring and improving performance.

I hereby would like to request to submit questionnaires to a percentage of professional nurses and nurse managers at the Roman Catholic Hospital. Enclosed please find copies of the two preliminary questionnaires for your perusal. Your favorable consideration will be appreciated.

All information will be treated in confidence and no reference will be made to a specific service or authority

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Yours sincerely

Ms Magdalene H. Awases

Local mailing address: P O Box 21748, Windhoek ***Tel. 264 811286393***

APPENDIX 4

The Medical Superintendent
Windhoek Central Hospital
Private Bag 13198
Windhoek

15 February 2006

Dear Sir/Madam

REQUEST FOR PERMISSION TO SUBMIT QUESTIONNAIRES TO PROFESSIONAL NURSES AND NURSE IN SUPERVISORY POSITIONS.

I am currently busy with research for the degree D Litt et Phil at the University of South Africa. The title of the intended thesis is ""*Factors affecting the performance of professional nurses in Namibia*" The study is undertaken towards the fulfillment of the requirements for the degree of D Litt et Phil degree at the University of South Africa.

The purpose of this study is to identify and analyze factors that negatively and positively affect performance of professional nurses in Namibia and to explore factors that are strongly associated with improved performance in order to suggest strategies for monitoring and improving performance.

I hereby would like to request to submit questionnaires to a percentage of your nurse managers and professional nurses at the Windhoek Central hospital. Enclosed please find copies of the two preliminary questionnaires for your perusal. Your favorable consideration will be appreciated. Permission for conducting research was granted by Dr K. Shangula, The Permanent Secretary, Ministry of Health and Social Services

All information will be treated in confidence and no reference will be made to a specific service or authority

Please find attached the letter of permission for your information.

Yours sincerely

Mrs. Magdalene H. Awases

Local mailing address: P O Box 21748, Windhoek ***Tel. 264 811286393***

APPENDIX 5

The Managing Director
Medi-Clinic Private Hospital
Heliodoor Street
Windhoek
Namibia

26 January 2006

Attention: Nursing Services Manager

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT PILOT STUDY.

I am a Namibian, employed by the World Health Organization, Regional Office for Africa in Brazzaville Congo. I am registered with the University of South Africa (UNISA) for a doctoral degree. The title of the intended thesis is "*Factors affecting the performance of professional nurses in Namibia*" I am expected to undertake research as part of the fulfillment of the requirements for the degree of D Litt et Phil degree at the University of South Africa.

The purpose of this study is to identify and analyze factors that negatively and positively affect performance of professional nurses in Namibia and to explore factors that are strongly associated with improved performance in order to suggest strategies for monitoring and improving their performance.

I am writing to seek permission to submit questionnaires to professional nurses and nurse in supervisory of management position the Medi-clinic hospital for the purpose of conducting a Pilot Study.

Please find attached copies of the two provisional questionnaires for your perusal.
Your favorable consideration will be much appreciated.

Yours sincerely

Ms Magdalene H. Awases

Local mailing address: P O Box 21748, Windhoek ***Tel. 264 811286393***

APPENDIX 6

QUESTIONNAIRE FOR PROFESSIONAL NURSES

SECTION A: PERSONAL INFORMATION.

*Please give your answer to each of the following questions. Read all answers first and choose the appropriate answer box by circling **only one number** for each question.*

1. Could you please tell us your age category?

20 years or lower	1
20 - 29 years	2
30 - 39 years	3
40 - 49 years	4
50 - 59 years	5
60 or over	6

2. What is your gender?

Female	1
Male	2

3. What is your highest qualification in nursing?

Diploma in nursing and midwifery.	1
BSc nursing and midwifery.	2
Postgraduate/ diploma in - Advanced midwifery - Nursing administration - Critical care - Community - Mental health	3
Bachelor's degree (e.g. BACur)	4
Master's degree (e.g. MA, MSC)	5
Doctoral degree (e.g. PhD, DLitt Soc)	6
Other:	7

4. How many years have you been a registered nurse?

0 - 5 years	1
6 -10 years	2
11- 15 years	3
16 -20 years	4
21 years or longer	5

SECTION B: ORGANIZATIONAL DEMOGRAPHICS

5. In which type of hospital are you currently employed?

Private	1
Public-intermediate hospital	2
Public-national referral hospital	3
District hospital	
Other:	

6. What is your current employment status in this organization?

Full-time	1
Part-time	2
Other:	3

7. In what type of discipline/clinical ward are you currently allocated (e.g surgical ward).

Surgical ward	1
Maternity ward	2
Paediatric ward	3
Outpatient	4
Medical ward	5
Critical/intensive care	6
Theatre	7
Other:	8

8. Indicate how long you have been working in this ward:

0 - 12 months	1
1 - 2 years	2
2 - 3 years	3
3 - 4 years	4
5 years and longer	5

SECTION C: SKILLS DEVELOPMENT, PERFORMANCE ASSESSMENT,

WORKSPACE AND INCENTIVES

9. Indicate how you regard your knowledge and skills in your current job position by placing an X in the appropriate box.

Please indicate your answers as follows:

1. Very Poor
2. Poor
3. Average
4. Good
5. Excellent

Knowledge/skills		**1**	**2**	**3**	**4**	**5**
9.1	Planning of nursing care.					
9.2	Implementing nursing care plans.					
9.3	Assessment of patient.					
9.4	Implementing of nursing performance standards.					
9.5	Health education.					
9.6	Clinical competencies.					
9.7	Interpersonal relations.					
9.8	Patient counselling skills.					
9.9	Self assessment with regard to outcome of performance.					
9.10	Supervision of nursing care.					
9.11	Supervising student nurses.					
9.12	In-service training.					
9.13	Management of time.					
9.14	Improvement of quality of care.					
9.15	Maintaining facilities, equipment and supplies.					

10. Which of these tasks did you find the most difficult and why?

……

……

……

11. Please indicate up to two other important competencies or skills you wish to acquire in your current position.

---

12. How, if at all, is performance reviewed in your organization for various categories of employees? Circle only one.

A formal system of regular appraisals with reviews of past performance, setting of objectives.	1
Informal, but regular reviews involving discussions about past performance and agreed actions for the future.	2
Informal, *ad hoc* reviews, undertaken especially when there is a performance problem.	3
Not reviewed,	4

13. If you have a performance appraisal system in place, how are the results of the performance appraisal utilised?

Training	1
Promotion	2
Demotion	3
Rotation	4
Not used	5

14. Indicate your responses to the following statements regarding performance appraisal and utilisation:

Please read each item in the following statements, and then indicate with an X in the appropriate answer box, according to the following code definitions:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	**1**	**2**	**3**	**4**	**5**
14.1	Objectives to be achieved are known by individuals to be assessed.					
14.2	Performance standards expected from staff are clear and understood by all.					
14.3	Constructive feedback on performance appraisal results is provided on a regular basis.					

14.4	Feedback of how staff is performing is provided throughout the year.					
14.5	Prompt action is taken when performance falls below acceptable standards.					
14.6	My managers/supervisor inspires me to do my best.					
14.7	Staff are given opportunity to make comments on the results of their performance.					

15. Please indicate your response to each of the following statements regarding your remuneration, benefits and recognition.

Indicate with an X in the appropriate answer box, according to the following code definitions.

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	**1**	**2**	**3**	**4**	**5**
15.1	Your remuneration is competitive compared to other similar organizations.					
15.2	Remuneration is in accordance with your experience.					
15.3	Remuneration is in accordance with your job responsibility.					
15.4	Fringe benefits are known to you.					
15.5	You are satisfied with your fringe benefits.					
15.6	Opportunities exist for career advancement.					
15.7	Hardworking nurses are recognised.					

16. Would you like to comment on any of your responses in question15?
.....
.....
.....
.....

17. Please indicate your response to each of the following statements regarding staffing and work schedules.

Indicate with an X in the appropriate answer box, according to the following code definitions:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	**1**	**2**	**3**	**4**	**5**
17.1	You get opportunities to make inputs into staffing policies and procedures.					
17.2	Opportunities exist for a flexible work schedule.					
17.3	The overall work schedule is fair.					
17.4	Overtime work is acceptable.					
17.5	There is a good balance between people who supervise work and people who do the work.					
17.6	The allocated staff in my unit is sufficient to cover the current workload.					
17.7	Care and support of staff in the form of counselling at the workplace is available.					

18. Please indicate your response to each of the following statements regarding staff development.

Please indicate with an X in the appropriate answer box, according to the following code definitions:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	**1**	**2**	**3**	**4**	**5**
18.1	Opportunities for advancing in the organization exist.					
18.2	Good opportunities for continuing education are available.					
18.3	The necessary training is given to ensure job effectiveness.					
18.4	Job specific refresher courses are available.					
18.5	In-service training adequately addresses the skill gaps.					
18.6	Incompetent nurses are identified and provided					

	with the necessary support.					
18.7	Good leadership/management training available.					
18.8	Professional nurses participate in identifying their staff development needs.					

19. Please indicate your response to each of the following statements regarding workspace and environment.

Please indicate with an X in the appropriate answer box, according to the following code definitions

1.Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	**1**	**2**	**3**	**4**	**5**
19.1	My work environment is safe and free from hazards.					
19.2	Good workplace layout.					
19.3	Comfortable temperature.					
19.4	Necessary instruments are available.					
19.5	Instruments in working conditions.					
19.6	Materials and supplies sufficient.					
19.7	antiseptic hand solution for protection of staff and patients are available.					
19.8	Infection control strategy guidelines available.					

SECTION D:

YOUR ORGANIZATION: OPINION SURVEY

Information to respondents

The questions in this section ask for your views about the organization where you work and some of its activities.

The Opinion Survey offers an opportunity to give honest and objective feedback. **Your responses are entirely confidential. No one in the Organization will see the answers you give,** so please answer the questions as honestly as possible. There are no 'right' or 'wrong' answers. It is your view that is important. The more honest you are, the more valuable your response will be.

Section D (a)

Each question is presented as a statement. Please read the statement carefully before replying. Some questions are framed as 'positive' statements (e.g. 'I find my job rewarding') whilst others are 'negative' (e.g. 'I am expected to meet impossible deadlines'). You will be asked to select one response that matches most closely with your **perception** of the statement.

When answering questions, remember that there are no right answers and it is your honest opinion that counts, not what you think you should say or what other people would say.

1. Strongly disagree
2. Disagree
3. Neither agree or disagree
4. Agree
5. Strongly agree

(1) Strongly disagree	(2) Disagree	(3) Neither agree or disagree	(4) Agree	(5) Strongly agree

Statement	**1**	**2**	**3**	**4**	**5**
20. I work with skilled competent people who are good at their jobs.					
21. My performance is judged more by how much work I do than by how well I do it.					
22. I find my work rewarding					
23. I am afraid to openly express my ideas and opinions.					
24. People in this organization have a shared sense of purpose.					
25. Doing this job makes me feel good about myself.					
26. I am subject to personal criticism and abuse					
27. People in this organization put more energy into identifying mistakes than into figuring out how to do things right.					
28. I do not like the way the organization operates					
29. The way things are organised around here makes it hard for people to do their best work.					
30. I am proud to tell people that I work for this organization.					
31. Some cultural believes in the community I am living is in conflict with some of my organization's policies.					
32. I am not included in hospital/ward in activities or made to feel part of the team.					
33. I am constantly seeking out new challenges at					

work.					
34. The community I live in has the highest regards for my organization.					

Section D (b)

Each question is presented as a statement. Please read the statement carefully before replying. You are asked to select one response that matches most closely with your **perception** of the statement.

1. Strongly disagree
2. Disagree
3. Neither agree or disagree
4. Agree
5. Strongly agree

(1) Strongly disagree	(2) Disagree	(3) Neither agree or disagree	(4) Agree	(5) Strongly agree

35. In this organization, people in different departments or programmes try to help each other.	**1**	**2**	**3**	**4**	**5**
36. Most people here know how their work contributes to this organization's mission.	**1**	**2**	**3**	**4**	**5**
37. I receive prompt acknowledgement and recognition for doing a good job.	**1**	**2**	**3**	**4**	**5**
38. My manager/supervisor inspires me to do my best.	**1**	**2**	**3**	**4**	**5**
39. Judgement about my performance is fair.	**1**	**2**	**3**	**4**	**5**
40.This organization's mission is understood by everyone who works here.	**1**	**2**	**3**	**4**	**5**
41. The people I work with are comfortable in suggesting changes and improvements to each other.	**1**	**2**	**3**	**4**	**5**
42. Senior managers in this organization are open to new ideas and suggestions.	**1**	**2**	**3**	**4**	**5**
43. I am clear about the objectives I need to achieve.	**1**	**2**	**3**	**4**	**5**

44. I trust and respect my immediate supervisor.	**1**	**2**	**3**	**4**	**5**
45. My manager emphasises my positive contributions when reviewing my performance.	**1**	**2**	**3**	**4**	**5**

46. When changes are made in the way things are done, management always first informs the people who will be affected.	**1**	**2**	**3**	**4**	**5**
47. There is a great deal of cooperation between people in this organization.	**1**	**2**	**3**	**4**	**5**
48. When I retire I will receive a reasonable pension from this organization.	**1**	**2**	**3**	**4**	**5**
49. I am given enough authority to allow me to do my job effectively.	**1**	**2**	**3**	**4**	**5**
50. If I have an idea for improving the way we do our work, my supervisor/manager will usually listen to me.	**1**	**2**	**3**	**4**	**5**
51. I feel my work contributes to the organization's performance.	**1**	**2**	**3**	**4**	**5**
52. The work I do gives me a feeling of personal achievement.	**1**	**2**	**3**	**4**	**5**
53. My pay is competitive to other, similar organizations.	**1**	**2**	**3**	**4**	**5**
54. My colleagues value my contribution.	**1**	**2**	**3**	**4**	**5**
55. My manager/supervisor gives me regular, timely feedback that helps me improve my performance	**1**	**2**	**3**	**4**	**5**
56. This organization provides me with skills and knowledge that will benefit my future career.	**1**	**2**	**3**	**4**	**5**

57. What are the things you most like about working for this organization?

---

58. What are the things you like least?

---

59. What would you most like to see changed/improved? (and any other relevant comments)

Thank you for taking time to participate in this survey.

APPENDIX 7

QUESTIONNAIRE FOR NURSING SERVICE MANAGERS AND WARD MANAGERS/SUPERVISORS

SECTION A

PERSONAL INFORMATION

Please give your answer to each of the following questions. Read all answers first and choose the appropriate answer box by circling ***only one number*** *for each question*

1. Could you please tell us your age category?

20 years or lower	1
20 -29 years	2
30 - 39 years	3
40 - 49 years	4
50 - 59 years	5
60 or over	6

2. What is your gender?

Female	1
Male	2

3. What is your highest qualification in nursing?

Diploma in nursing and midwifery	1
BSc nursing and midwifery	2
Postgraduate/ diploma in - Advanced midwifery - Nursing administration - Critical care - Community health - Mental Health	3
Bachelor's degree (e.g. BA Cur)	4
Master's degree (e.g. MA, MSC)	5
Doctoral degree (e.g PhD, DLitt Soc)	6
Other:	7

4. How many years have you been a registered nurse?

0 - 5 years	1
6 -10 years	2
11 - 15 years	3
16 - 20 years	4
21 years and longer	5

SECTION B: ORGANIZATIONAL DEMOGRAPHICS

5. In which type of hospital are you currently employed?

Private	1
Public-intermediate hospital	2
Public-national referral hospital	3
District hospital	4
Other	5

6. Please indicate your current position within the hospital.

Deputy Director	1
Nursing Service Manager	2
Chief Nursing Officer	3
Principal professional nurse	4
Senior professional nurse	5

SECTION C

MANAGEMENT, SKILLS DEVELOPMENT, PERFORMANCE ASSESSMENT, WORKSPACE AND INCENTIVES

7. Have you as a manager been involved with any of the following?

Answer either NO (1) or YES (2) for each of the following.

	TASK	**NO**	**YES**
7.1	Providing training to employees.		
7.2	One-to-one performance interview related to performance outcome.		
7.3	Placement of staff according to skills.		

7.4	Orientation of new staff.		
7.5	Managing conflict.		
7.6	Operational research.		
7.7	Counselling of employees.		

8. Which of these tasks did you find the most difficult and why?
……
……
……

9. Have you received any management training or training in specific aspects related to management?

NO	1
YES	2

10. If you answered YES in question 9, please give the following particulars regarding management training or training in aspects related to management which you received. If your answer was NO in question 9, please go to question 11 (ignore question 10).

10.1	Please indicate course(s) received and duration of course in days.	
10.2	Indicate institution:	
	■ A University	1
	■ A Technical College	2
	■ A Business School	3
	■ Regional Office	4
	■ Other: please specify	5
10.3	To what extend do you consider your training to be sufficient:	
	■ Not at all	1
	■ To some degree	2
	■ To a large degree	3
	■ To a very large degree	4

11. Indicate how you regard your management skills for overseeing the effective functioning of the ward(s) under your supervision.

Please indicate as follows:

1. Very Poor
2. Poor
3. Average
4. Good
5. Excellent

		1	2	3	4	5
Knowledge/skills						
11.1	Nursing service policy implementation.					
11.2	Planning nursing service delivery.					
11.3	Nursing audit					
11.4	Development of nursing performance standards.					
11.5	Development of competencies.					
11.6	Skills development.					
11.7	Interpersonal relations.					
11.8	Counselling skills.					
11.9	Performance appraisal of subordinates.					
11.10	Supportive supervision.					
11.11	Problem solving					
11.12	Motivation of staff.					
11.13	Organising facilities, equipment and supplies.					

12. How, if at all, is performance reviewed in your organization for various categories of employees?

A formal system of regular appraisals with reviews of past performance and setting of objectives.	1
Informal, but regular reviews involving discussions about past performance and agreed actions for the future.	2
Informal, *ad hoc* reviews, undertaken especially when there is a performance problem.	3
Not reviewed.	4

13. Indicate your response to the following questions regarding performance appraisal and utilisation in your organization or unit.

Please read each item in the following questions, and then indicate with an X in the appropriate answer box, according to the following code definitions:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	**1**	**2**	**3**	**4**	**5**
13.1	Objectives to be achieved are known by individuals to be assessed.					
13.2	One-to-one performance interview on the outcome of performance appraisal is conducted.					
13.3	Performance standards expected from staff are clear and understood by all.					
13.4	Peer review of performance is done.					
13.5	Constructive feedback on performance appraisal results is provided on a regular basis.					
13.6	Feedback of how staff is performing is provided throughout the year.					
13.7	Prompt action is taken when performance falls below acceptable standards.					
13.8	Managers/supervisor inspires staff to do their best.					
13.9	Staff are given an opportunity to make comments on the results of their performance.					
13.10	Self assessment by employees to review their own performance is done.					

14. Please indicate your response to each of the following questions regarding your remuneration, benefits and recognition.

Indicate with an X in the appropriate answer box, according to the following code definitions

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	1	2	3	4	5
14.1	Your remuneration is competitive compared to other similar organizations.					
14.2	Remuneration is in accordance with your experience.					
14.3	Remuneration is in accordance with your job responsibility.					
14.4	Fringe benefits are known to you.					
14.5	You are satisfied with your fringe benefits.					
14.6	Opportunities exist for career advancement.					
14.7	Hardworking nurses are recognised.					

15. Would you like to comment on any of your responses in question14?
.....
.....
.....
.....

16. Please indicate your response to each of the following questions regarding staffing and work schedules.

Indicate with an X in the appropriate answer box, according to the following code definitions:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	1	2	3	4	5
16.1	You get opportunities to make inputs into staffing policies and procedures.					
16.2	Opportunities exist for a flexible work schedule.					
16.3	The overall work schedule is fair.					
16.4	Overtime work is acceptable.					
16.5	There is a good balance between people who supervise work and people who do the work.					
16.6	The allocated staff in my unit are sufficient to cover the current workload.					
16.7	Care and support of staff in the form of counselling at the workplace is available.					

17. Please indicate your response to each of the following regarding staff development.

Please indicate with an X in the appropriate answer box, according to the following code definitions:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	**1**	**2**	**3**	**4**	**5**
17.1	Opportunities for advancing in the organization exist.					
17.2	Good opportunities for continuing education are available.					
17.3	The necessary training is given to ensure job effectiveness.					
17.4	Job specific refresher courses are available.					
17.5	In-service training adequately addresses the skill gaps.					
17.6	Incompetent nurses are identified and provided with the necessary support.					
17.7	Good leadership/management training is available.					
17.8	Professional nurses participate in identifying their staff development needs.					

18. Please indicate your response to each of the following statements regarding workspace and environment.

Please indicate with an X in the appropriate answer box, according to the following code definitions:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	**1**	**2**	**3**	**4**	**5**
18.1	My work environment is safe and free from hazards.					
18.2	Good workplace layout.					
18.3	Comfortable temperature.					
18.4	Necessary equipment are available.					
18.5	Equipment in working condition.					

18.6	Materials and supplies are sufficient.					
18.7	Antiseptic hand solution for protection of staff and patients are available.					
18.8	Infection control strategy guidelines are available.					
18.9	Necessary policies are available.					

Indicate your response to each of the following statements with regard to management and leadership.

Please place an X in the appropriate answer box, according to the following code definitions:

1. Do not know
2. Do not agree
3. Tend to agree
4. Fully agree

	Statement	**1**	**2**	**3**	**4**
19.1	Leadership style is the way in which the management philosophy manifests itself in practice.				
19.2	The leadership style of nurses in our country over the last 20 years, has been one of democratic leadership.				
19.3	Problem solving is more successful when managed immediately by the supervisor, rather than involving the specific subordinates.				
19.4	Nurse managers should possess adequate communication skills.				
19.5	Due to the heavy work load of managers, it is not expected that they should have a training function.				
19.6	Patient care is the primary function of the manager; therefore personnel management can be managed by the personnel department.				
19.7	Extrinsic motivation of employees involves stimulation of goal achievement.				
19.8	Management's leadership style has an effect on the level of performance inclination.				
19.9	A position of authority is required in management positions to ensure successful influencing of subordinates.				
19.10	Traditionally, nurse managers in Namibia have had an autocratic style of management.				
19.11	Participative management involves shared decision-making.				
19.12	Employees who receive frequent feedback concerning their performance, are usually more highly motivated than those who do not.				

SECTION D:

YOUR ORGANIZATION: OPINION SURVEY

Information to respondents

The questions in this section ask for your views about the organization where you work and some of its activities.

The Opinion Survey offers an opportunity to give honest and objective feedback. **Your responses are entirely confidential. No one in the Organization will see the answers you give,** so please answer the questions as honestly as possible. There are no 'right' or 'wrong' answers. It is your view that is important. The more honest you are, the more valuable your response will be.

Section D (a)

Each question is presented as a statement. Please read the statement carefully before replying. Some questions are framed as 'positive' statements (e.g. 'I find my job rewarding') whilst others are 'negative' (e.g. 'I am expected to meet impossible deadlines'). You will be asked to select one response that matches most closely with your **perception** of the statement.

When answering questions, remember that there are no right answers and it is your honest opinion that counts, not what you think you should say or what other people would say.

1. Strongly disagree
2. Disagree
3. Neither agree or disagree
4. Agree
5. Strongly agree

(1) Strongly disagree	(2) Disagree	(3) Neither agree or disagree	(4) Agree	(5) Strongly agree

Statement	**1**	**2**	**3**	**4**	**5**
20. I work with skilled competent people who are good at their jobs.					
21. My performance is judged more by how much work I do than by how well I do it.					
22. I find my work rewarding					

23. I am afraid to openly express my ideas and opinions.					
24. People in this organization have a shared sense of purpose.					
25. Doing this job makes me feel good about myself.					
26. I am subject to personal criticism and abuse					
27. People in this organization put more energy into identifying mistakes than into figuring out how to do things right.					
28. I do not like the way the organization operates					
29. The way things are organised around here makes it hard for people to do their best work.					
30. I am proud to tell people that I work for this organization.					
31. Some cultural believes in the community I am living is in conflict with some of my organization's policies.					
32. I am not included in hospital/ward in activities or made to feel part of the team.					
33. I am constantly seeking out new challenges at work.					
34. The community I live in has the highest regards for my organization.					

Section D (b)

Each question is presented as a statement. Please read the statement carefully before replying. You are asked to select one response that matches most closely with your **perception** of the statement.

1. Strongly disagree
2. Disagree
3. Neither agree or disagree
4. Agree
5. Strongly agree

(1) Strongly disagree	(2) Disagree	(3) Neither agree or disagree	(4) Agree	(5) Strongly agree

35. In this organization, people in different departments or programmes try to help each other.	**1**	**2**	**3**	**4**	**5**

36. Most people here know how their work contributes to this organization's mission.	**1**	**2**	**3**	**4**	**5**
37. I receive prompt acknowledgement and recognition for doing a good job.	**1**	**2**	**3**	**4**	**5**
38. My manager/supervisor inspires me to do my best.	**1**	**2**	**3**	**4**	**5**
39. Judgement about my performance is fair	**1**	**2**	**3**	**4**	**5**
40. This organization's mission is understood by everyone who works here.	**1**	**2**	**3**	**4**	**5**
41. The people I work with are comfortable in suggesting changes and improvements to each other.	**1**	**2**	**3**	**4**	**5**
42. Senior managers in this organization are open to new ideas and suggestions.	**1**	**2**	**3**	**4**	**5**
43. I am clear about the objectives I need to achieve.	**1**	**2**	**3**	**4**	**5**

44. I trust and respect my immediate supervisor.	**1**	**2**	**3**	**4**	**5**
45. My manager emphasises my positive contributions when reviewing my performance.	**1**	**2**	**3**	**4**	**5**
46. When changes are made in the way things are done, management always first informs the people who will be affected.	**1**	**2**	**3**	**4**	**5**
47. There is a great deal of cooperation between people in this organization.	**1**	**2**	**3**	**4**	**5**
48.When I retire I will receive a reasonable pension from this organization.	**1**	**2**	**3**	**4**	**5**
49. I am given enough authority to allow me to do my job effectively.	**1**	**2**	**3**	**4**	**5**
50. If I have an idea for improving the way we do our work, my supervisor/manager will usually listen to me.	**1**	**2**	**3**	**4**	**5**
51. I feel my work contributes to the organization's performance.	**1**	**2**	**3**	**4**	**5**

52. The work I do gives me a feeling of personal achievement.	**1**	**2**	**3**	**4**	**5**
53. My pay is competitive to other, similar organizations.	**1**	**2**	**3**	**4**	**5**
54. My colleagues value my contribution.	**1**	**2**	**3**	**4**	**5**
55. My manager/supervisor gives me regular, timely feedback that helps me improve my performance	**1**	**2**	**3**	**4**	**5**
56. This organization provides me with skills and knowledge that will benefit my future career.	**1**	**2**	**3**	**4**	**5**

57. What are the things you most like about working for this organization?

---

58. What are the things you like least?

---

59. What would you most like to see changed/improved? (and any other relevant comments)

Thank you for taking time to participate in this survey.

APPENDIX 8

FACTORS AFFECTING PERFORMANCE QUESTIONNNAIRE

FOR

PROFESSIONAL NURSES

Madam/Sir

Kindly spare a few moments to complete this questionnaire designed for a research study entitled “Factors affecting performance of professional nurses in Namibia”

PURPOSE THE STUDY

To identify and analyze factors that negatively and positively affect performance of professional nurses in Namibia and to explore factors that are strongly associated with improved performance in order to suggest strategies for monitoring and improving their performance.

UNDERTAKING

All information provided will be treated with the utmost confidentiality and anonymity. You are not required to provide your name in the questionnaire.

INSTRUCTIONS

1. Please answer all questions.
2. Complete questionnaires by either circling or placing an x in the appropriate answer box or providing the information requested.
3. Please complete the questions as honestly, frankly and objectively as possible.
4. Please answer the questions as they apply to you personally.
5. Please return questionnaires by placing it in the designated container in your ward.

APPENDIX 9

CRONBACH'S ALPHA TEST FOR INTERNAL CONSISTENCY-QUESTIONNAIRE 1

Reliability: Q. 9

Case Processing Summary

		N	%
Cases	Valid	124	84.4
	Excluded[a]	23	15.6
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.905	.909	15

Reliability: Q. 14

Case Processing Summary

		N	%
Cases	Valid	139	94.6
	Excluded[a]	8	5.4
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.850	.850	7

Reliability: Q. 15

Case Processing Summary

		N	%
Cases	Valid	135	91.8
	Excluded[a]	12	8.2
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.846	.845	7

Reliability: Q. 17

Case Processing Summary

		N	%
Cases	Valid	141	95.9
	Excluded[a]	6	4.1
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.794	.798	7

Reliability: Q. 18

Case Processing Summary

		N	%
Cases	Valid	136	92.5
	Excluded[a]	11	7.5
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.899	.901	8

Reliability: Q. 19

Case Processing Summary

		N	%
Cases	Valid	115	78.2
	Excluded[a]	32	21.8
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.871	.870	8

Q20-56

Reliability: Mission and Goals

Case Processing Summary

		N	%
Cases	Valid	146	99.3
	Excluded[a]	1	.7
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.564	.548	4

Reliability: Reward and Recognition

Case Processing Summary

		N	%
Cases	Valid	143	97.3
	Excluded[a]	4	2.7
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.635	.641	5

Reliability: Commitment and Satisfaction

Case Processing Summary

		N	%
Cases	Valid	136	92.5
	Excluded[a]	11	7.5
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.360	.347	6

Reliability: Management style

Case Processing Summary

		N	%
Cases	Valid	147	100.0
	Excluded[a]	0	.0
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.742	.740	7

Reliability: Performance

Case Processing Summary

		N	%
Cases	Valid	142	96.6
	Excluded[a]	5	3.4
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.503	.471	7

Factor Analysis: Mission and Goals

Reliability: Mission and Goals (minus Q 43)

Case Processing Summary

		N	%
Cases	Valid	146	99.3
	Excluded[a]	1	.7
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.643	.644	3

Reliability: Commitment and satisfaction

Case Processing Summary

		N	%
Cases	Valid	144	98.0
	Excluded[a]	3	2.0
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.601	.597	4

Factor Analysis

Reliability2: Performance (27, 29)

Case Processing Summary

		N	%
Cases	Valid	145	98.6
	Excluded[a]	2	1.4
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.681	.680	5

Reliability: Interpersonal relations (35, 41, 47, 54)

Case Processing Summary

		N	%
Cases	Valid	147	100.0
	Excluded[a]	0	.0
	Total	147	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.503	.517	4

APPENDIX 10

CRONBACH'S ALPHA TEATS FOR RELIABILITY (INTERNAL CONSISTENCY)- QUESTIONNAIRE 2

Reliability: Q. 11

Case Processing Summary

		N	%
Cases	Valid	39	92.9
	Excluded[a]	3	7.1
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.885	.888	13

Reliability: Q. 13

Case Processing Summary

		N	%
Cases	Valid	36	85.7
	Excluded[a]	6	14.3
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.922	.923	10

Reliability: Q. 14

Case Processing Summary

		N	%
Cases	Valid	40	95.2
	Excluded[a]	2	4.8
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.818	.821	7

Reliability: Q. 16

Case Processing Summary

		N	%
Cases	Valid	41	97.6
	Excluded[a]	1	2.4
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.723	.719	7

Reliability: Q. 17

Case Processing Summary

		N	%
Cases	Valid	41	97.6
	Excluded[a]	1	2.4
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.846	.845	8

Reliability: Q. 18

Case Processing Summary

		N	%
Cases	Valid	41	97.6
	Excluded[a]	1	2.4
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.912	.911	9

Reliability: Q. 19

Case Processing Summary

		N	%
Cases	Valid	36	85.7
	Excluded[a]	6	14.3
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.650	.670	12

Q20-56

Reliability: Mission and Goals

Case Processing Summary

		N	%
Cases	Valid	40	95.2
	Excluded[a]	2	4.8
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.598	.585	4

Factor Analysis: Mission and goals

Communalities

	Initial	Extraction
sdq24 People in this organisation have a shared sense of purpose.	1.000	.185
sdq36_1 Most people here know how their work contributes to this organisation's mission.	1.000	.486
sdq40_1 This organisation's mission is understood by everyone who works here.	1.000	.778
sdq43_1 I am clear about the objectives I need to achieve.	1.000	.400

Extraction Method: Principal Component Analysis.

Total Variance Explained

	Initial Eigenvalues			ction Sums of Squared Loac		
Compon	Total	of Varianumulative		Total	of Varianumulative	
1	1.849	46.223	46.223	1.849	46.223	46.223
2	.964	24.099	70.322			
3	.807	20.169	90.491			
4	.380	9.509	100.000			

Extraction Method: Principal Component Analysis.

Component Matrix [a]

	Compone nt
	1
sdq40_1 This organisation's mission is understood by everyone who works here.	.882
sdq36_1 Most people here know how their work contributes to this organisation's mission.	.697
sdq43_1 I am clear about the objectives I need to achieve.	.633
sdq24 People in this organisation have a shared sense of purpose.	

Extraction Method: Principal Component Analysis.

a. 1 components extracted.

Reliability2: Mission and goals (minus Q. 24)

Case Processing Summary

		N	%
Cases	Valid	40	95.2
	Excluded[a]	2	4.8
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.643	.640	3

Reliability2: Commitment and satisfaction (Q25, 30, 33)

Case Processing Summary

		N	%
Cases	Valid	42	100.0
	Excluded[a]	0	.0
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.509	.514	3

Factor Analysis: Commitment and satisfaction

Communalities

	Initial	Extraction
sdq25 Doing this job makes me feel good about myself.	1.000	.808
sdq26r	1.000	.698
sdq28r	1.000	.700
sdq30 I am proud to tell people that I work for this organisation.	1.000	.799
sdq33 I am constantly seeking out new challenges at work.	1.000	.511
sdq56_1 This organisation provides me with skills and knowledge that will benefit my future career.	1.000	.720

Extraction Method: Principal Component Analysis.

Reliability: Performance

Case Processing Summary

		N	%
Cases	Valid	41	97.6
	Excluded[a]	1	2.4
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.664	.668	6

Reliability: Management style

Case Processing Summary

		N	%
Cases	Valid	41	97.6
	Excluded[a]	1	2.4
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.593	.639	7

Reliability: Reward and recognition

Case Processing Summary

		N	%
Cases	Valid	41	97.6
	Excluded[a]	1	2.4
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.531	.565	6

Reliability: Interpersonal relations

Case Processing Summary

		N	%
Cases	Valid	41	97.6
	Excluded[a]	1	2.4
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.591	.605	6

Reliability2: Interpersonal relations (minus 32)

Case Processing Summary

		N	%
Cases	Valid	41	97.6
	Excluded[a]	1	2.4
	Total	42	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.670	.678	5